Maternal and Child Health Services Title V Block Grant

State Narrative for Louisiana

Application for 2011
Annual Report for 2009

Document Generation Date: Thursday, July 15, 2010

Table of Contents

I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.
An attachment is included in this section.

B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

C. Assurances and Certifications

Assurances and Certifications will be maintained on file in the MCH program's central office. Requests for copies of these documents may be obtained by sending a written request by fax to (504) 568-3503 or by mail to the following address:

MCH Block Grant Coordinator
Office of Public Health
Maternal and Child Health Section
1010 Common Street
Suite 2710
New Orleans, LA 70112

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published March 2009; expires March 31, 2012.

E. Public Input

Public input for the 2010 needs assessment placed significant emphasis on consumer feedback and stakeholder engagement. MCH conducted a consumer survey which assessed the importance of MCH issues including women's health, infant health, child health, adolescent health, oral health and access to services. Clients of the state's 82 parish health units were asked to participate in the survey over a two month period. Over 2,500 clients provided valuable feedback on the MCH issues most important to them.

Stakeholder engagement for the 2010 needs assessment was conducted at the community, regional and state levels. MCH staff presented epidemiological data along with consumer survey feedback to community groups, regional stakeholders and state level stakeholders in an effort to assess priority MCH needs and discuss practical strategies for implementation. Stakeholders totaling 576 participants across the state, included Regional Fetal and Infant Mortality Review Community Action Team and Case Review Team members, Office of Public Health regional staff, and regional representatives from the Office of Addictive Disorders, HIV/AIDS Program, Family Planning Program, Healthy Start Programs, Nurse Family Partnership Program, Tobacco Control Program, Tobacco Free Living Program, Children's Cabinet Advisory Board, Early Childhood Comprehensive Systems interagency committee, School Based Health Centers, American Academy of Pediatrics-Louisiana Chapter, child death review panels, EMSC Advisory Council, safety and injury advocates, first responders, law enforcement, Oral Health Coalition members, dental health professionals, dental associations, families of children with special health care needs (CSHCN), CSHCN affiliated agencies, local hospital leadership, MCH advocacy organizations, and academic institutions.

Results of the needs assessment will be disseminated to the public using a variety of methods. MCH's Partners for Healthy Babies site will include a list of the leading MCH priority needs as well as provide links on the DHH website for public access and review. MCH will also share the results of the needs assessment with all stakeholders via the existing Fetal and Infant Mortality Review and Screening Brief Intervention Referral and
Treatment regional networks, MCH Coalition members, and other partners.

The Title V Application is accessible to all Louisiana's citizens via Internet access. A summarized version of the application was posted to the MCH website on 5/10/10 (see attachment) and a notice of the posting of the grant was published in the Louisiana Register in June 2010. The summary document was reviewed by 30 Children with Special Healthcare Needs (CHCN) Stakeholders from all 9 administrative regions of the state.

An attachment is included in this section.

II. Needs Assessment

In application year 2011, the 2010 Needs Assessment will be attached to this Section II.

An attachment is included in this section.

C. Needs Assessment Summary

The MCH staff in collaboration with MCH stakeholders identified the following priority needs in the 2010 Needs Assessment: 1) Decrease infant mortality through the reduction of preterm births in the African American population; (2) Decrease intentional and unintentional injuries in the maternal, child, adolescent, and CSHCN populations; (3) Improve preconception and interconception health among Louisiana women (4) Reduce unintended pregnancies and reduce births spaced at less than 24 months apart; (5) Increase care coordination for CSHCN and their families; (6) Improve the nutritional health of the maternal and child population with a focus on obesity prevention and breastfeeding; (7) Assure that strategies and methods in MCH and CSHCN programs are culturally competent to reduce racial disparities; (8) Improve oral health of MCH and CSHCN population by increasing access to preventive measures and access to oral health care; (9) Improve the behavioral health of the MCH and CSHCN populations through prevention, early intervention, screening, referral, and treatment, where appropriate; (10) Increase preventive services for adolescents and transition services for youth with special health care needs (YSHCN).

Similar to the 2005 Needs Assessment, the MCH program formed a steering committee that planned and organized the 2010 Needs Assessment. Based on the successful planning and implementation of the needs assessment in 2005, the steering committee again decided to organize the 2010 Needs Assessment into five subgroups: Adolescent Health, Child Health, Maternal Health, Oral Health, and Children with Special Health Care Needs.

Many of the priority needs identified in the 2010 Needs Assessment mirrored those priority needs identified in 2005. However, there were several noteworthy changes in priority needs identified and shifts in program focus that are reflected in the 2010 priority needs selected. Priority needs in 2005 that were absent from the 2010 priority needs list remain important. The absence of specific priority needs indicates the success of the MCH program in addressing these particular priority areas. Despite their absence the MCH program continues to be vigilant in monitoring these priority areas.

Decreasing intentional and unintentional injuries among maternal, child, adolescent, and children with special health care needs (CYSHCN) populations , increasing care coordination for CSHCN and their families, improving the nutritional health of maternal and child populations with a focus on obesity prevention and breastfeeding, improving oral health of MCH and CSHCN populations, and improving the mental health of MCH and CSHCN populations were each identified as priority needs in 2005 and remain top priorities in 2010.

As alluded to previously, the 2010 needs assessment includes several new priorities. These priority needs were decreasing infant mortality by reducing preterm births among African Americans (Priority Need #1) improving preconception and interconception health (Priority Need #3), Reducing unintended pregnancies and births spaced at less than 24 months (Priority Need #4), assuring that strategies and methods in programs are culturally competent (Priority Need #7) and increasing preventive services for adolescents and transition services for (YSHCN) (Priority Need #10).

In 2005, decreasing infant mortality and morbidity by partnering with regional stakeholders was a top priority. Specifically, the priority need in 2005 was to "decrease infant mortality and morbidity

in collaboration with regional coalitions comprised of public and private health and social service providers". In 2010 this priority need was modified in an effort to gain better precision in targeting those factors that influence infant mortality (IMR) and morbidity. By focusing on the African American population, who has disproportionately higher IMR's than whites, reflects the MCH program's commitment to reducing the primary driver of the state's overall high IMR and also reflects the programs commitment to reducing race based health disparities. The reduction of race disparities remains an important objective of the MCH program. This resulted in the inclusion of priority need #7. Programs such as Partners for Health Babies and the Nurse Family Partnership continue to develop marketing materials and other programming that are culturally competent. In addition, the epidemiology staff, monitor data on race and ethnicity in an effort to support and inform program decisions. New activities also include partnering with the state's Tobacco Control Program and Tobacco Free Living Program to develop cessation programs for pregnant women. The MCH program will provide resources to staff a full time position that will work with Tobacco Control staff to develop and evaluate approaches that ensure tobacco referrals and interventions are culturally competent. In 2009, The Stork Reality, a social marketing campaign with a focus on preconception health, was launched. In addition, more resources to address preconception and interconception health are expected with a new initiative from the Department of Health and Hospitals (DHH) that will focus on improving birth outcomes. The Stork Reality campaign also provides information to the public on the high rate of unintended pregnancy. The CSHS subgroup formed a new stakeholder advisory group with representatives from all public health programs within the DHH and the Department of Social Services. This group is charged with providing services for YSHCN and their families and improving care coordination.

Priority needs continue to be reviewed to assess program progress, strengths and to identify changes in health status. By utilizing current data and working with community partners and other stakeholders, the MCH program continues to strive to improve the health of the state's MCH populations.

An attachment is included in this section.

III. State Overview

A. Overview

Overall Health Status

A 2009 report by the United Health Foundation ranks Louisiana 47th out of 50th in overall health, representing the third least healthy state in the nation. This ranking reflects a marked improvement over recent years, with the change from 2008 to 2009 identified as the state with the second greatest improvement in overall health during that time. The report is based on 22 core measures, including infant mortality, adequacy of prenatal care, immunization coverage, infectious diseases, obesity, cigarette smoking, binge drinking, children in poverty, health insurance, and several other measures. Louisiana's poor ranking stems from its high infant mortality rate, high rate of cancer and cardiovascular deaths, high rate of premature death, high rate of infectious diseases, high rate of uninsured population, high rate of preventable hospitalizations, and low high school graduation rate. Over the past year, 2008 to 2009, the average health dollars targeted toward public health programs and initiatives in Louisiana has decreased from $94 to $90 per person.

Louisiana has among the lowest life expectancy rates in the United States. These rates result partly from the high burden of chronic disease in Louisiana as well as racial disparities in these diseases. The rates of death from heart disease, cancer, stroke are high in Louisiana. In 2006 age adjusted rates, Louisiana ranks ninth highest for heart disease and stroke mortality and fifth highest for cancer mortality in the United States. According to 2005 data from the BRFSS survey based on self-reported height and weight, the highest prevalence rates of obesity in the United States were seen in Louisiana, Mississippi and West Virginia. According to the 2009 Trust for America's Health Report, Louisiana has the 8th highest rate of adult obesity and the 7th highest rate of overweight youths (ages 10-17) in the nation. The most recent BRFSS data on hypertension show that in 2007, reproductive aged White women were 15% likely to have hypertension while almost a quarter of Black women had hypertension (23.2%). On self ranking in 2008 13.7% of reproductive aged women (15-44) in Louisiana ranked their health as Fair/Poor (9.5% White women, 18.8% Black women).

According to the 2009 National Kids Count Data Book, Louisiana ranked 49th out of the 50 states in "Indicators of Child Well-being." Specifically, Louisiana ranked 49th for both infant mortality and percent of low birth weight infants; 42nd in child deaths; 43rd in teen deaths; 39th for the teen birth rate; 47th for the percent of teens who are high school dropouts; and 45th for percent of teens not attending school and not working. The state ranked 48th, 49th and 49th in the percent of children in poverty; the percent of children in families where no parent has a full-time, year around employment; and the percent of families with children headed by a single parent each of these measures, respectively.

Overall Economic Well-Being

Geographically, Louisiana is a southern state that is predominantly rural. It is divided into 64 parishes, with 29 designated as urban, or being part of a Metropolitan Statistical Area (MSA). Although Louisiana is a rural state, approximately 74% of the state's population live in an urban designated parish (MSA), and six of those parishes are located in the greater New Orleans metropolitan area. The U.S. Office of Management and Budget defines a MSA as having a core urban area of 50,000 or more population.

According to the US Census from 2000 to 2008, the total population of Louisiana fell by 1.3% from 4,468,976 to an estimated 4,410,796 people. In terms of racial makeup, Louisiana has two main racial groups, White 64.8% and Black 32.0%, with 3.2% as other. This is vastly different from the racial makeup of the US, where in 2008, an estimated 79.8% of the population is White, 12.8% of the population is Black, and 7.4% is other. Louisiana has a relatively small Hispanic population compared to the US as a whole, although the proportion of Hispanic individuals has increased since the 2005 hurricanes. A comparison of Louisiana and the Nation's racial and

Hispanic origin distributions is available in Figure 1 and Figure 2 of Appendix A respectively. In 2008, the total number of Louisiana women of childbearing age has decreased from 1,005,468 (22.5% of total population) in 2000 to 920,873 (20.9% of total population). In 2008, teenagers 15-19 years comprised approximately 7.5% of Louisiana's population and 20.7% of the population were children 0-14 years. The state population estimates from 2000 and 2008 can be found in Appendix B, Table 1.

Personal income and education levels in Louisiana directly impact the well-being status of mothers, children, and families. In 2008, the US Bureau of Economic Analysis reported Louisiana a having a per capita personal income of $36,371 compared to the national average $40,208. This shows an increase of 2.8% from 2005. In 2008 Louisiana median household income was $43,635 a 2% increase since 2003. The unemployment rate, reported by the Louisiana Department of Labor, in December of 2009 was 7.5%, as compared to a national unemployment rate of 10%. Both rates have risen since 2008 when Louisiana had an unemployment rate of 5.5% and the national unemployment rate was 7.4%. According to the 2008 U.S. Census Bureau's American Community Survey, only 35% of the State's population 25 years of age and over, graduated with a 12th grade education, and 7.1% had less than a 9th grade education.

According to the US Census Bureau American Community Survey, Louisiana had an overall poverty rate of 17.3% in 2008, accounting for approximately 730,000 people. Mississippi was the only state to exceed this rate, with a rate of 21.2%. The US Census Bureau reported a 2008 national rate of 13.2%, up from 12.5% in 2007. From 2006-2008, the U.S. Census also showed that approximately 25% of African Americans and Native Americans live less than 100% of the federal poverty level compared to about 10% of Caucasians. The National Center for Children in Poverty reported that 252,603 (23%) Louisiana children under the age of 18 years were considered poor in 2006-2008, 4% more than the National average of 19%. Only Mississippi and the District of Columbia exceeded this rate. When considering only children under the age of 6 years, 25% of Louisiana's young children were considered poor, 3% more than the National average of 22%.

Healthcare Access

Approximately 25% of Louisiana residents live in rural areas, but only 14% of primary care physicians practice in rural areas. Health Professional Shortage Area designations (HPSA), are areas which lack access to primary care providers (i.e., family practice, OB/GYN, pediatrics, internal medicine, and/or general practice), dental providers, and/or mental health providers. Of the 64 Louisiana parishes, there are 60 primary care HPSAs; 52 mental health HPSAs, and 56 dental HPSAs. In Louisiana, 87.5% of the state is a Dental Health Professional Shortage Area, having on average, 40% less dentists and 42% less dental hygienists than other states. There are 34 parishes without access to a Medicaid OB/GYN provider and 6 parishes which only have access to 1 Medicaid OB/GYN provider (See Appendix C, Map 4).

The Louisiana Medicaid 2007-08 Annual Report indicated that approximately 27% of Louisiana's population received Medicaid services, which is an increase from 25% in 2006. According to 2009 Louisiana Health Insurance Survey (LAHIS), the estimate for uninsured children under age 19 years who were eligible for Louisiana Medicaid in 2009 was 5.3% (39,765) statewide, a decline from 5.5% in 2007. Medicaid is a source of coverage for 43.4% (510,266) of children under age 19 years in Louisiana. However, the LAHIS 2009 statewide uninsured estimate for non-elderly adults (19-64) less than 200% of the federal poverty level was 20.1% (540,490) -- only a 0.1% decline from 2007. According to the 2007 and 2009 AAP State Reports on Children's Health Insurance Status & Medicaid/CHIP Eligibility & Enrollment, the percentage of uninsured adolescents decreased from an estimated 13.8% in 2006 to 12.6% in 2008, respectively, whereas the National Survey of Children's Health also showed a decrease in the percentage of uninsured adolescents ages 12-17 years from 9.5% in 2003 to 6.2% in 2007.

Revenue shortfalls continue to challenge the delivery of state services to Louisianans. Recurring revenues are insufficient to cover expenses, and the FY2011 budget eliminates nearly 3,000

state jobs, including 1,300 filled positions. It also reduces spending in nearly every state department and agency. Streamlining recommendations include the consolidation of agencies to eliminate duplication of services, and outsourcing or privatizing state services. In accordance with Louisiana's 2009 legislative Act 384, the Office of Behavioral Health within DHH was formed on July 1, 2010 by consolidating the existing Office for Addictive Disorders and Office of Mental. The Healthcare Reform Act of 2007 mandated DHH to redesign the healthcare system based on the Medical Home model to create a more cost-efficient system with more emphasis on preventive care. DHH is planning to establish a managed care system of Coordinated Care Networks (CCNs) and phase out the current fee-for-service delivery system.

Most preventive health services for children and adolescents with Medicaid and LaCHIP are rendered by private healthcare providers. Federally Qualified Health Centers, Rural Health Centers, and the 65 School-based Health Centers (SBHCs) also provide preventive and primary healthcare services. However, only 8% of public school students receive services through SBHC's. According to Medicaid data, there were over 500 providers that provided services to 354,887 KIDMED or EPSDT recipients from the state fiscal year of July 2007- June 2008. Medicaid-eligible children who received a paid service by Medicaid increased from 70.7% in 2001 to 83.2% in 2006 to 89.9% in 2008. Medicaid enrollees under age 1 year who received at least one periodic screen increased from 88.7% in 2004 to 89.9% in 2008, and LaCHIP enrollees under age one year who received at least one periodic screen increased from 86.4% in 2004 to 91.3% in 2008. Also, The National Immunization Survey showed that more children were immunized, an increase to 81.9% in 2008 from 61.9% in 2002 in the percent of 19 to 35 month olds who received the full schedule of age appropriate immunizations. Louisiana Medicaid-eligible adolescents ages 15-18 years who received at least one initial or periodic screen increased from 52% in FY 05 to 67% in FY09 and from 52% to 72% for ages 10-14 years. However, according to the National Survey of Children's Health, only 49.1% of children ages 12-17 years received health care that meets the AAP definition of medical home in 2007 compared to 65.8% in 2003. Not all adolescents receive the recommended course of immunizations, but in 2008, estimated immunization coverage for Louisiana adolescents ages 13-17 years was at the national average for MMR; above national average for TDaP/TD and MCV4; and just below national average for VAR (with no varicella history), Hep B, and HPV.

MCH Health Status Indicators

Risk-appropriate prenatal care services play an important role in identifying medical and behavioral factors that can cause poor birth outcomes. Low income women often enter pregnancy with poor management of pre-existing health problems, face a burden of illness stemming from poverty that cannot be reversed or adequately modified during prenatal care, and are at greater risk for experiencing poor maternal and birth outcomes. Therefore, women with pre-existing chronic health conditions must receive disease and medication management prior to conception in order to improve birth outcomes in Louisiana.

Early access to prenatal care and adequacy of prenatal care services are important in reducing poor birth outcomes. The percent of women entering prenatal care in the first trimester has risen from 84.1% in 2004 to 86.9% in 2007. The Black to White disparity ratio for first trimester entry into prenatal care has remained around 1.5 each year from 2004 to 2007. A 2009 United Health Foundation report ranked Louisiana as 3rd in the nation for adequacy of prenatal care. Based on the Kotelchuck index, which measures early and adequate prenatal care, 84.8% of women received early and adequate prenatal care during pregnancy in 2007. The Black to White ratio of early and adequate prenatal care remained constant at 1.1 from 2004 to 2007, with 88.8% of White women and 79.2% of Black women receiving early and adequate care in 2007. Medicaid is currently the primary mechanism for women to access prenatal services in Louisiana. In 2007, Medicaid covered 68.4% of all deliveries, which includes 90.1% of all Black births and 53.8% of White births.

Between 2000 and 2007, Louisiana experienced a 2.6% decline in the number of live births. In 2007, Louisiana had 66,063 live births (See Appendix A, Figure 3 for additional years). In 2007,

13.8 % of all Louisiana resident births were to teens, and there was a decrease in the rate of Louisiana teen births age 15-17 years, from 34.8 per 1,000 female teens in 2000, to 26.8 per 1,000 in 2005, with an increase to 29.5 per 1,000 in 2006. A greater decrease in teen births from 2000 to 2007 occurred to Black teens of 21.4% compared to a 3.6 decrease for White teens.

The infant mortality rate in Louisiana decreased from 10.4 in 2004 to 9.0 per 1,000 live births in 2007. The 2007 IMR (rate=9.0 per 1,000) was the lowest reported since the year 2000 rate of 8.9 per 1000 live births, in part due to underreporting of infant deaths weighing less than 500-grams at birth. For the 2005-2007 combined period, the Black IMR of 14.9 was more than twice that of the rate of 6.5. The ratios of Black to White IMR for the state were 2.1, 2.5, and 2.2 in 2005, 2006, and 2007, respectively. Disparities in the infant mortality rate are seen when looking at the nine different regions of the state which reflect differences in socioeconomic status and resource availability throughout the State.

Very low (VLBW) and low birth weight (LBW) are major risk factors associated with infant mortality and with preterm births. There has been little change in the VLBW or LBW rates in Louisiana (See Appendix A, Figure 6). A very slight decrease in VLBW was noted from 2.3% in 2001 to 2.2% in 2006 and 2007. The 2007 rate of VLBW births among Whites was 1.3% compared to 3.7% for Blacks. The racial disparity of VLBW births, indicated by the Black to White ratio, fell from 2.9 in 2004 to 2.5 in 2005, but rose to 2.7 in 2006 and returned to 2.9 in 2007. The percentage of LBW infants were 10.5% in 2001 to 11.0 in 2004, 11.5 in 2005, 11.4 in 2006, and 11.3 in 2007, with 15.8% of Black infants delivered LBW in 2007, compared to 8.4% of White infants. From 2004 to 2006, the rate of LBW births was approximately 2 times higher among Black women as compared to White women. Louisiana has very high rate of preterm birth (PTB) and infant mortality. The 2007 rate of PTB was 13.0% compared to 13.8% in 2006. Rates of late PTB have risen from 8.4% in 2002 to 9.3% in 2004 to 9.8% in 2006. The first decrease in several years was seen in 2007, with a rate of 9.1%.

Injuries are the leading causes of death for Louisianans ages 1 month- 44 years. The most common causes of pregnancy-associated death were motor vehicle accidents, homicide and obstetric causes of death occurring while pregnant or within 42 days after delivery, and rates of the pregnancy-associated deaths for Louisiana have fallen in recent years, from 89.2 in 2005 to 83.9 in 2006 to 80.2 per 100,000 in 2007. Child death rate increased from 30.8 deaths per 100,000 children in 2000 to a high of 35.5 in 2004 to a low of 21.7 in 2006, rebounding slightly to 25.3 in 2007. The 2005-2007 leading causes of deaths to children aged 1 to 14 years were unintentional injury followed by homicide and diseases of the nervous system. For 2005-2007 combined, Motor vehicle crash (MVC) deaths accounted for the largest number of unintentional injury deaths (rate=5.2 per 100,000) followed by drowning and fire (rates=2.1 and 1.8 per 100,000, respectively). Rates of child abuse and neglect increased from 9.3 per 1,000 population under 18 years of age in 2008 to 11.7 per 1,000 in 2006 and decreased to 9.2 per 1,000 in 2008. The top three leading causes of death for adolescents in Louisiana from 2005 to 2007 were unintentional injury (44% of deaths, rate=41.8 per 100,000), intentional injury/homicide (30%, rate=28.4), and diseases of the circulatory system (4%, rate=4.2). In 2007, the leading cause of death for all adolescents was injury, with unintentional injury as the leading cause of death among White adolescents and intentional injury among Black adolescents.

Behavioral Health

Substance use during pregnancy is routinely monitored in Louisiana in an effort to target resources to improve pregnancy outcomes. According to PRAMS data, the percent of women reported smoking during the last trimester of pregnancy increased from 11.8% in 2002 to 12.6% in 2007, with such associated factors as low educational attainment, being unmarried, and life stressors such as having a lot of unpaid bills, being in a physical fight, and having someone close with a drinking or other substance use problem. Women reported drinking during the third trimester increased from approximately 4.9% in 2002 to 6.8% in 2004, and then to 5.5% in 2007, with being in a physical fight as an associated factor. A 2000-2004 PRAMS study indicated that White women were 6.6 times as likely to report cigarette use in the last trimester compared to

Black women, and White women were 70% more likely to report alcohol use compared to Black women. Screening, Brief Intervention, Referral and Treatment 4PsPlus screening tool, showed that among women screened in private obstetrical provider sites cumulative between 5/05/05-12/30/09, 18.3% used tobacco cigarettes, 6.7% used alcohol, 3.2% used marijuana, 0.5% used drugs since they knew they were pregnant. Among women in WIC sites cumulative between 7/16/05-12/30/09, 14.4% used tobacco cigarettes, 3.7% used alcohol, 1.8% used marijuana, 0.1% used drugs since they knew they were pregnant. Results also showed that 7.1% of all screened pregnant women identified at risk for domestic violence and 16.4% identified at risk for depression in 2009.

Louisiana children have a higher prevalence of behavioral, emotional, and developmental issues than the national average (35% vs.26%). Rates of child abuse and neglect increased from 9.3 per 1,000 population under 18 years of age in 2008 to 11.7 per 1,000 in 2006 and decreased to 9.2 per 1,000 in 2008. Historically, cases of child neglect comprises approximately one third of the validated cases. According to the 2007 National Survey of Children's Health, 10.2% of children live with parents who experience high levels of stress from parenting. High stress is reported more often by the parents of children living in single-mother households. Based on the Federal Office of Special Education Programs school exit categories, 72% of students with emotional disturbance dropped out of school for the 2006-07 school year while 45% of special education students dropped out.

According to the 2008 Communities that Care Survey, alcohol is the most commonly used substance among adolescents in Louisiana. The average age for initiation of alcohol use was 12.5 years. About 26.8% of 6th, 8th, 10th and 12th graders surveyed stated that they had used alcohol in the past month and 50.8% reported using alcohol at least once in their lifetime. Cigarettes were the second most commonly used substance among adolescents in Louisiana. The 2008 Louisiana CCYS showed that 28.6% of students in grades 6th, 8th, 10th, and 12th used cigarettes at least once in their lifetime and 10.7% of students in the same grades used cigarettes at least once in the past 30 days; the average age for initiation of cigarette use was 12.1 years.

Nutritional Health

Louisiana PRAMS data collected from 2002-2004 and 2007, identified that only 34.8 % of Louisiana women achieved appropriate weight gain as recommended by the Institute of Medicine, with 23.1% under-gaining and 42.1% over-gaining. The percent of women in the overweight category (pre-pregnancy BMI=25 to <30) was 22.9%, 22.8% and 21.2% in 2002, 2004, and 2007, respectively. The percent of women in the obese category (pre-pregnancy BMI= 30+) was 19.5%, 21.5% and 21.3% in 2002, 2004, and 2007, respectively.

The Pediatric Nutrition Surveillance System collects information on nutritional parameters among children under 5 years who are enrolled in the Women, Infants, and Children Supplemental Food Program (WIC). In 2007 the percent of children (2 to 5 years) who were obese (at or above the 95th percentile) in Louisiana was 13.8% compared with a national percentage of 14.9%. During the 2007-2008 school year, height and weight taken on approximately 12,000 children (2-19 yrs old) seen in School Based Health Centers in Louisiana revealed 46.5% are considered overweight or obese. In Louisiana the most common WIC nutrition risk codes include inappropriate feeding practices for children (20.75 %), environmental tobacco smoke exposure (9.0%), low hemoglobin or hematocrit values (7.88%), and pre-pregnancy or postpartum overweight (6.48%).

Oral Health

Only 41% of Louisiana residents receive fluoridated water, and only three of seven urban areas have fluoridated water. According to the 2008 Behavioral Risk Factor Surveillance System, 54.5% of Louisiana residents with an annual income of less than $15,000 per year did not visit a dentist or dental clinic. Access to Medicaid dental providers is very limited, especially in rural areas and for Medicaid-eligible pregnant women. Medicaid-eligible children from low income families have more untreated dental caries than children from higher income families, and they suffer from

dental disease at a rate almost five times greater than their more affluent counterparts. Also, racial disparities in dental care were evident, with 32.4% of Black women reported seeing a dentist during their pregnancy in 2007 compared to 39.8% of White women, according to LaPRAMS.

Current Priorities and MCH Roles and Responsibilties
Louisiana Department of Health and Hospitals has begun to implement the new "Birth Outcomes Initiative". This collaborative effort of the all DHH agencies will provide policy and service changes to address the primary health care, chronic disease management and social support needed to produce improvements in Louisiana's birth outcomes. Plans are being developed to expand care coordination for subsequent poor pregnancy outcomes to Medicaid-eligible high risk women who had a preterm or low birth weight delivery and have diabetes, hypertension, or other chronic diseases. The Family Planning Program will provide such MCH-funded services as the distribution of multivitamins which include folic acid, referrals to the FAX to Quit Tobacco Cessation Program which provides follow up to women interested in stopping smoking. MCH continues to fund Nurse Family Partnership, social marketing efforts of Partners for Healthy Babies and the SIDS Risk Reduction and Safe Sleep Program, Fetal-Infant Mortality Review, sudden unexpected infant death case reviews of Louisiana Child Death Review, and the MCH Child Safety Coordinators' community efforts to reduce unintentional injury deaths of infants.

Despite extensive planning and preparations after the storms of 2005, natural, biological, and manmade events, recently and over the last two years, continue to pose challenges for public health, especially in meeting the needs of the MCH population. During the 2008 storms, Hurricanes Gustav and Ike, safe sleep surfaces/portable cribs and items to meet the immediate basic personal hygiene and nutritional needs of infants and toddlers were again absent or inadequate. To assure that the needs of infants and toddlers will be met during disasters, the state has begun to incorporate the recommendations outlined in Appendix C of the National Commission on Children and Disasters' 2009 Interim Report to U.S. Congress. DHH's Office of Public Health addressed the challenge of the H1N1 pandemic by prioritizing the availability of vaccine for pregnant women, young children, and parents and other caregivers of children under 6 months of age at state public health units, in mobile public health strike teams services to schools, at qualified pharmacies statewide, and at private healthcare delivery sites who received vaccines through the state. With the massive British Petroleum oil spill in the Gulf of Mexico, Louisiana is burdened with another manmade disaster of mass proportions, and its financial impact on the state and its long term implications on the health and well-being of its citizens are still unknown.

Louisiana Maternal and Child Health Program, along with key stakeholders, performed the 2010 Title V Needs Assessment to identify leading and emerging health and safety issues impacting women, infants, and children (including those with special health care needs) in Louisiana. Survey findings from consumers and stakeholders, state and local level capacity assessment results, and currently available MCH and CYSHCN data trends were used to determine the top 10 priority needs of Louisiana's MCH and CYSHCN population groups. The next steps are to create an action plan for the period of 2010-2015 that addresses the top 10 priority needs; to allocate MCH Title V Block Grant funding and other resources in a manner that reflects the concerns of Louisiana citizens and health/safety experts, data trends, and the state's capacity to meet the priority needs; to monitor progress using State Performance Measures, National Performance Measures, Outcome Measures, Health Status Indicators, Health System Capacity Indicators; and to report back to stakeholders on a regular basis. Despite some improvements, results from the 2010 needs assessment process showed that leading problems identified in 2005, such as infant mortality, child injuries, care coordination for the CSHCN population and oral health, persist today, while underscoring the need for greater emphasis on obesity prevention and interconceptional healthcare. Also, the 2010 Needs Assessment showed that such contributing factors as geography as well as racial and ethnic disparities in health status, poverty, and low education levels continue to pose unique challenges to the delivery of Title V services in Louisiana.

Children and Youth with Special Health Care Needs

Overall Population of CYSHCN in Louisiana

According to NS-CSHCN 05/06, 14.8% of children in LA are CYSHCN. LA ranks 26th in the nation for percent of CYSHCN, which is a decrease from the 2001 NS-CSHCN when LA was ranked 2nd at 15.9%. This decrease is thought to be due at least in part to shifts in the population after Hurricanes Katrina and Rita, when CYSHCN with severe, chronic conditions were less likely to return to LA when the healthcare infrastructure was greatly disrupted. The largest reported proportion of CYSHCN in LA is 6-11 year olds, followed closely by 12-17 year olds. The largest proportion is non-Hispanic (NH) multi-race (23.7%), followed by NH-White (15.7%), then NH-Black (12.8%). Among Hispanic children (14%), the majority report English as the primary language. There is little variation in percent CYSHCN by income strata, although there is a slightly higher percent among those living below 100% FPL.

Between the 2 NS-CSHCN years, health outcomes among LA's CYSCHN population, as reflected by the MCHB Core Outcome Measures, have greatly improved. LA moved from below the national average in all 6 NPMs in 2001 to above the national average in all but early and continuous screening and transition in 2005/06.

Health Insurance

The percent CYSHCN with health insurance has improved greatly in recent years due to CSHS, Medicaid, LaCHIP outreach efforts, expansion of LaCHIP coverage through the LaCHIP affordable plan, and new programs for CYSHCN, including the Medicaid Purchase plan and the Family Opportunity Act. Overall, 65.5% of CYSHCN families say they have adequate insurance (US 62%)(NPM 4). Of those with insurance, a greater percent say it is adequate (71.8% LA vs. 66.9% US). CYSHCN with functional limitations and those with emotional, behavioral or developmental issues were more likely to say their insurance was inadequate.

About 45% of CYSHCN in LA are publically insured, which is much higher than the national average of 28.6%*. Unfortunately, having health insurance does not guarantee access to care or quality of services. The top five priority needs among CYSHCN families who answered the Family Survey is providers that take Medicaid, specifically pediatricians, subspecialists, dentists, and occupational and physical therapists (OT, PT). Results were similar across geographic areas, race, and age. When questioned about difficulties associated with access to subspecialists, overall 24% said the needed subspecialist was not in their geographic area. Approximately one-fifth relayed that the subspecialist did not accept their type of health insurance. Physicians also ranked this as a top priority need of families with CYSHCN. The subspecialties where more than 50% of the physicians relayed difficulties in accessing were psychiatry, developmental/ behavioral pediatrician, neurology, orthopedic, and dermatology. Because of this lack of access despite an increase in public insurance coverage, CSHS will continue to provide a safety net of select subspecialty clinics according to regional need. CSHS will also continue to assist families in identifying appropriate health insurance options.

Morbidity

The most common conditions among CYSHCN in LA in decreasing order are allergies (54.5%), attention deficit hyperactivity disorder (ADHD) (40.5%), asthma (36%), emotional problems (20%), headaches (20.8%), and developmental delay (DD) or intellectual disability (10.9%), The percent receiving SSI for these conditions is: allergies 45%, ADHD 53.5%, asthma 43%, emotional condition 33%, headaches 25%, and DD 50%. Having any of these conditions is associated with having other conditions as well, and all but asthma are associated with four or more functional difficulties. Of these, ADHD, asthma, and DD are more common among the publically insured than privately insured, and all but allergies and asthma are more common among the uninsured than the insured. While none of these are qualifying diagnoses for CSHS subspecialty clinics, CSHS serves these CYSHCN through its medical home (MH) care

coordination (CC) program and other population based and infrastructure building activities.

Disparities exist among CYSHCN with functional difficulties and among those with emotional, behavioral, or developmental issues. While the rate of functional difficulties is similar to the national average, a larger proportion of NH-Black CYSHCN reported having a functional difficulty compared with NH-White (91.6% vs.80.5%*). Also, CYSHCN living at less than 200% FPL were twice as likely to have a functional impairment as those living above 200% FPL*. CYSHCN without health insurance (5.1%) were twice as likely to have four or more functional difficulties*.

LA children have a higher prevalence of behavioral, emotional, and developmental issues than the national average (35% vs.26%). NH-Black CYSHCN are 50% more likely to report having a behavioral, emotional or developmental issue than NH-White CYSHCN (36% vs. 23%), and CYSHCN living below the 100% FPL were more likely than those living above 200% FPL (35.9% vs. 20.4*). Those with a behavioral, emotional or developmental issue are three times more likely to say the service system is not organized, and were more likely to need their physician to communicate with the school or other programs (56.1% vs.16.6%*). Those with functional difficulties or emotional, behavioral or developmental issues were also more likely to say their condition caused financial burden on the family.

LA's CYSHCN had a higher proportion who needed durable medical equipment (DME) during the 12 months prior to the survey (11.4% vs.15.7% US *). The need was greater in younger children. There is a two-fold gap for need between NH-Black CYSHCN and their NH-White counterparts (23.3% vs.11.2 %*), and the need was also greater in publically insured CYSHCN than those with private insurance (22.6% vs.9.8 %*). CSHS will continue to provide DME in its regional subspecialty clinics, and to assist families with inadequate insurance.

Geographic Disparities and NPMs

LA is above the national average for 4 of the 6 NPMs. CYSHCN living in suburban and rural areas are more likely to meet all 6 NPMs, despite the concentration of providers in urban areas. For NPM 2, over 62.2% of families felt like partners in decision making vs. 67.2% US. For suburban CYSHCN, 75.9% met this measure and for rural, 71.1 %, which was higher than urban CYSHCN (58.4 %*), and higher than those living in large towns (51.9 %*). Coordinated care in a MH (NPM 3) was obtained by 49.6% of LA's CYSHCN vs. 47.1% US. Suburban and rural CYSHCN had 57.9% and 59.6% respectively, compared with urban 49.6% and large town 48.2%. Urban CYSHCN were also more likely than rural or suburban to say they had no usual source of care when sick. More than 65% reported adequate insurance coverage (NPM 4) vs. 62% US. Urban CYSHCN had the lowest rate (58.1%), but this was not statistically different from the other three groups (suburban: 72.7%; large town: 74.2%; rural: 74%). A higher proportion of urban families said their insurance was inadequate compared to rural. Early and continuous screening (NPM 1) was met by 54.3% of CYSHCN vs. 63.8% US. The rate was highest among suburban CYSHCN (60.4%), followed by rural respondents (58.5%), urban (55.7%), and lastly large town CYSHCN (40.7%). For services are easy to use (NPM 5), 89.3% of CYSHCN met this goal vs. 89.1% US. This was highest for rural and suburban CYSHCN (94.1% and 93.2% respectively). Among YSHCN, 40.9% received the transition services necessary to make the appropriate transitions to adult healthcare, work, and independence (NPM 6) vs. 41.2% US. This rate was highest for rural (58.5%), followed by suburban (48.6%), urban (36.5%), and large town youth (36.4%). In summary, percent CYSHCN meeting the NPMs was lower in urban areas and large towns than suburban and rural areas for all 6 NPMs, although not all differences were statistically significant.

Medical Home

Equal proportions of CYSHCN and non-CYSHCN met the AAP definition of receiving care within a MH (51.3% vs. 56.6%), and while LA does well compared to other states (49.6% vs. 47.1% US) (NPM3), more than half of CYSHCN are without a MH. Those with a single mother had half the prevalence than CYSHCN living with two parents. The prevalence also increase with income, and was significantly different from the lowest level compared to the two highest levels (34.6% vs.

56.7%, and 60.8 %*). Only 44% of publically insured CYSHCN received MH services, compared to 61.1% of privately insured*. This is surprising since receipt of KIDMED services in LA requires linkage with a MH. CYSHCN with a MH were more than 3 times as likely to say the system is easy to use, were 2.5 times more likely to say their provider spent enough time with them, were 2 times more likely to say they were satisfied with their provider communication, and were almost 2 times less likely to need their providers to communicate with schools/other programs.

Physician surveys reveal many areas where MH capacity in the state can be improved. Less than one-third of physicians referred to Families Helping Families (FHF) or other family/parent support groups. Pediatricians were significantly more likely to refer than were family physicians (FPs). When looking at referral to other resources, more than 50% of physicians referred to OT, PT, and speech therapy, WIC, DME, Part C early intervention, Medicaid, Head Start, and special education. Half referred for 504 Accommodations. Less than half referred for assistive transportation, Title V programs, SSI/SSI-DI, respite care, LA Rehabilitation Services, and Family Supports and Services/Waivers. Pediatricians were more likely to discuss referral for therapies, WIC, Part C, Head Start, IEPs and 504 Accommodations. FPs were more likely to discuss referral for Medicaid. Family Survey results indicate that almost two-fifths of families reported difficulties accessing community resources/supports because their doctor did not know about resources and/or eligibility requirements. CSHS will increase infrastructure building/enabling service activities by working with MHs statewide to increase their capacity for CC, including improving physician knowledge of public health (PH) and community resources. CSHS will also work with FHF and F2FHICs to provide enabling services for families related to advocacy and service system navigation and to improve coordination and knowledge of services among regional program staff.

Usual Source of Care

LA's PH system is historically based on a Charity Hospital system as opposed to a preventive outpatient clinic system of care. A significantly larger proportion of LA's CYSHCN had two or more visits to a hospital emergency room (26.1% vs. 19.3% US*) and the prevalence rate for those who do not have a usual source for sick and/or preventive care is significantly higher than the US (10.1% vs. 6.4% US*). This was more common among NH-Black CYSHCN than NH-White (18.7% vs. 2.9 %*). Usual source of care when sick varies with insurance type; 66% of publically insured used a doctor's office vs. 89.3% *of privately insured. Significant differences were also seen for these two groups for citing a clinic, health center, or other regular source of care (7.4 vs. 22.7 %*). CYSHCN below the 100% FPL were less likely to have a usual source of care than those at higher income brackets (66.9% vs. 88.6%-91.1 %*).

While 88.6% of LA children/youth received a preventive visit in the year prior to the NS-CSHCN survey, similar to the US (88.5%), perception of need for routine preventive care was lower. Only 69.8% of LA's CYSHCN parents responded that their child/youth needed routine preventive care in the 12 months prior to the survey (US 77.9 %*). CSHS staff work with families of CYSHCN to stress the importance of preventive care and help families without a usual source of care to find a MH.

Oral Health

Compared to non-CYSHCN, a lower prevalence of CYSHCN reported their teeth were in excellent or very good condition (71.4% vs. 63.5 %). More CYSHCN experienced two or more problems in the 6 months prior to the survey than non-CYSHCN (16.1% vs. 7.8 %*). In LA, 97.3% of CYSHCN reported that they received needed preventive dental care. CSHS clinics assist CYSHCN to obtain dental care in the private sector. In Region 1, CSHS supports a dental clinic for CYSHCN provided by LSU Dental School.

Provider Cultural Competence

Most physicians claimed to consider family educational level, cultural background, household composition, religion, gender roles, ethnicity and language in communicating healthcare information. Only 29.5% said they consider the need for a translator. Most (78.5%) also said their

patients could speak directly to the physician when needed, and most (65.1%) say that they schedule extra time for CYSHCN when needed. This was more common among pediatricians than FPs. However, disparities do exist for whether families felt that providers sometimes or never spent enough time. Based on LA data from NS-CSHCN, a greater proportion of NH-Black CYSHCN than NH-White CYSHCN felt as though their doctors and other healthcare providers sometimes or never spent enough time with them (47.3% vs. 12.7%*). Those living below the 100% FPL were almost twice as likely to say providers spent insufficient time compared to the upper two income levels, and those with public insurance were half as likely to say doctors spent enough time. Similarly, more NH-Black than NH-White CYSHCN relayed that their doctors/other health care providers sometimes or never listened carefully to them (20.6% vs. 8.8%*), indicating that disparities exist.

Care Coordination

Compared to non-CYSHCN, CYSHCN had almost 5 times the prevalence rate for not receiving needed CC (7.9% vs. 34.4 %*). CC is an important part of MH for CYSHCN, yet data shows there were no differences in receipt of help with CC by MH status; those without a MH have a 7.5% decreased rate for help compared to those with a MH (32.5% vs. 40.0%). Compared to the US, LA's CYSHCN families spend significantly more hours each week providing and/or coordinating their child/youth's health care (5-10 hours/week: 12.9% vs. 8.9%*). More time is spent for younger children. Publically insured CYSHCNs' families are more likely to spend 11+ hours each week spent coordinating care compared to privately insured (18.9% vs. 4.9%*). CYSHCN with functional limitations required the most time (27%).

Physician Surveys revealed that of respondents, only 39.3% reported they provided their patients with a written plan of care. Many also do not refer to PH and community resources (see MH section). Only 49.1% reported that their patients' plans of care involve coordination with schools. Yet almost all respondents relayed that they helped communicate clinical information to the sub-specialist (92%), and most reported (93.5%) that they discuss subspecialist findings with the CYSHCN/family and integrate them into the care plan.

In addition to providing CC in CSHS clinics, CSHS works with medical practices to improve their capacity to provide CC. By focusing on teaching clinics and large private practices, CSHS hopes to improve CC in existing as well as future MHs. This priority is reflected in the new CSHS SPM of increasing the capacity for CC in PH systems. The goal is to decrease the disparity between percent publically insured and privately insured CYSHCN who receive CC from by 11%.

Transition

Based on data from the NS-CSHCN 40.9% of LA's YSHCN receive services to make appropriate transitions (US 41.2%), although data also indicates disparities. Comparing YSHCN by race/ethnicity, data showed that more NH-Black YSHCN did not receive the needed transition services compared to NH-White YSHCN (78.4% vs. 47.5%*). Youth who live at or below 99% FPL and 100%-199% FPL were less likely to receive transition services than those at or above 400% FPL (29.9%, and 29% vs. 59.1%*). YSHCN with functional limitations were 20% less likely to receive transition services than those whose conditions were managed by prescriptions.

Unlike CC, NS-CSHCN survey results indicate that YSHCN in LA with a MH have a 30% higher prevalence rate for receipt of transition services compared to those without (59.4% vs. 27.1%*). Family surveys indicate that the percent of YSHCN that have a MH varies greatly by region, from 61.5% in Region 5 to 100% in Region 7. This indicates a need to link YSHCN to PCPs to increase receipt of transition services. The Family Survey also indicates many areas where transition services can be improved in MHs. Among 87% of respondents that have a PCP, only 47% said their PCP discussed health/dental insurance options, 34% reported their PCP discussed finding an adult PCP, only about 29% relayed that their PCP discussed community-based resources, slightly more discussed future work/education choices, and 42.1% reported their PCP discussed the youth's role in managing their health care routine. When answers were stratified by race, a lower proportion of NH-Black YSHCN reported they had a PCP than NH-

White YSHCN; however, NH-Black YSHCN with a PCP reported a greater proportion in receipt of services for all five transition questions than NH-White YSHCN.

Among providers, 72% of FPs, and 10.7% of pediatricians relayed that transition services were not applicable because they serve patients from childhood through adulthood. However, transition services are not necessarily contingent upon the patient transferring from their care. Less than one-fifth of physicians reported that they discussed all the independent living skills with their YSHCN patients (16.9%). Of these three skills, less than one-quarter relayed that they discussed community-based resources, 45.4% said they discussed educational/vocation choices, while 61% discussed the patient's role in managing their health care. The more frequently reported services were providing counseling directly to YSHCN (64.9%), and ensuring that their patients have established an adult PCP (79.2%). Discussion about health/dental insurance options was low (36.4%). This is consistent with NS-CSHCN data that only 27.9% of families report that anyone had discussed insurance options, despite the fact that CYSHCN in LA are mostly in older age groups that will soon age out of Medicaid. CSHS will use this information to enhance its CC program in MHs by increasing technical assistance on transition.

Community/ Service System

Despite an overall high rate (89.3%) for LA CYSHCN reporting that services were organized in ways that families could easily use (NPM5), NS-CSHCN indicates about 12,823 CYSHCN experienced difficulty accessing a needed service. This type of difficulty is experienced equally for all income levels, and is higher for the publically insured than privately or uninsured. This may in part be explained by the Agency Survey, which indicates that the nine PH programs serving CYSHCN do not collaborate with each other to serve families. On average, about one-fifth of respondents cited a lack of knowledge about other programs as a reason for not referring clients to other programs' services. Only FHF, a community agency, reported to collaborate with all public health programs.

CSHS has a new stakeholder group with representatives from each of these programs which is working to improve collaboration. FHF has agreed to do in-services for regional program staff to improve referral/collaboration between programs. CSHS also participates in a DSS-DHH Data Integration Project to develop a master patient database between the two agencies. The database will indicate which programs clients are enrolled in/eligible for.

Special Education

CYSHCN represented 13% of LA schoolchildren. Among public school students, 16.3% were enrolled in special education; among private school students, only 2.5% were enrolled. The most common type of disability was a specific learning disability, followed by a speech or language impairment. Equal proportions were represented for DD, other health impairment, and mental disability. Among public school students, prevalence rates for special education enrollment differed by race/ethnicity category. Among American-Indian students, almost 14% were in special education, shortly followed by African-American students. The third highest rate was 12.6% among White students. Approximately 7.2% of Hispanic and slightly fewer than 5% of Asian students received special education.

Based on the Federal Office of Special Education Programs school exit categories, 45% of special education students dropped out of school for the 2006-07 year. Among students with emotional disturbance, 72% dropped out. Similarly, among students with profound mental disabilities, 66% did not complete school. Slightly more than half of students completed school among those with a specific learning disability, speech/language impairment, other health impairment, and mild mental disability. The remaining disability categories have a dropout rate which ranges from 38.1% for severe mental disability to 12.2% for autism.

CC and transition services in the MH include working with schools to be sure CYSHCN receive needed educational services to optimize success and independence. CSHS is working with MHs, FHF, and other public health programs to optimize success of CYSHCN in school and ensure that

they receive appropriate educational, vocational and transitional services.

CSHS and DHH Priorities
The Healthcare Reform Act of 2007 mandated DHH to redesign the healthcare system based on the MH model to create a more cost-efficient system with more emphasis on preventive care. DHH submitted a waiver to CMS in December 2008 to convert Medicaid into a managed care system of Coordinated Care Networks (CCNs). The waiver is waiting CMS approval. CSHS has participated on various healthcare reform committees including the MH Committee of the LA Healthcare Quality Forum, the state's legislated stakeholder group to advise administration on implementation of MH concepts. CSHS presented its data demonstrating success of CC in a MH post-Katrina to the state's first MH Summit, and continues to be involved in committee activities to ensure that the needs of CYSHCN are met.
note: *p<.05 statistically significant

An attachment is included in this section.

B. Agency Capacity

The State Maternal and Child Health Program is housed in the Office of Public Health (OPH), Department of Health and Hospitals (DHH). The mission of DHH is "to protect and promote health and to ensure access to medical, preventive, and rehabilitative services for all citizens of the State of Louisiana. The Department fulfills its mission through direct provision of quality services, the development and stimulation of services of others, and the utilization of available resources in the most effective manner." The other agencies under the Department include the Office of Mental Health, Office for Citizens with Developmental Disabilities, Office of Aging and Adult Services, and the Office for Addictive Disorders. Other related sections of DHH include the Bureau of Health Services Financing (Medicaid), Bureau of Primary Care and Rural Health, and the Bureau of Minority Health Access. The Assistant Secretaries for each of these Offices meet weekly to collaborate and coordinate services.

Personal health services and local public health functions are provided by 68 OPH parish health units distributed throughout 62 of the 64 parishes in the state, except in New Orleans and Plaquemines Parish, which have their own independent health departments (See Map 1 parish health units). OPH has 9 Regional Directors who supervise the health units, regional CSHS clinic sites, and regional health staff in their respective regions. The Adolescent School Health Initiative provides funding and technical assistance to 65 contract school-based health centers, and 1 federally funded school-based health center. Orleans Parish operates an independent health department and receives support from MCH to enhance Healthy Start services and provide Lead Poisoning Prevention services. MCH services are also provided through other medical and social services entities. Plaquemines Parish operates a health department which provides pregnancy testing, immunizations, and infectious disease services.

In the past decade there has been a dramatic increase in Medicaid coverage of the maternal and child population in Louisiana through the Child Health Insurance Program, LaCHIP and LaMOMS (pregnant women coverage), expanding eligibility to 200% of the federal poverty guidelines. This health coverage and the statewide expansion of Community Care, Louisiana's Medicaid Managed Care system using a primary care case manager model has reduced the need for MCH to provide direct medical services in most areas of the state. Pregnant women and children ages 0-21, who live in areas with no access to prenatal or preventive health care in the private sector, are served by MCH in parish health units whose services are linked with Women, Infants, and Children (WIC) Supplemental Food Program, Immunization, Family Planning, and Sexually Transmitted Disease services. The majority of the parishes with poor access to MCH services are in the northern regions of Louisiana. MCH provides pregnancy testing; and screening, brief intervention, and referral for maternal substance abuse, depression, and intimate partner violence, in collaboration with the state Offices of Addictive Disorders and Mental Health. The OPH parish health units primarily provide the following services including, WIC, Tuberculosis and

Sexually Transmitted Disease Control Programs, Immunization Program, Family Planning Program. As parish health unit based maternity and preventive child health services were transitioning to the private sector with Medicaid eligibility changes in the 1990's, MCH shifted funding to enabling, population-based, and infrastructure building services.

Understanding the social determinants of health, MCH invested in social marketing campaigns since 1994, to promote early access to prenatal care, healthy prenatal behaviors, and safe sleep environments for infants. More recently, MCH added a lifespan approach by including pre/interconceptional health messaging to the social marketing campaigns. In 1999, MCH began to invest in the evidence-based Nurse Family Partnership (NFP) Program, initiating the program in 2 regions of the state. Today NFP services exist in 52 of the 64 parishes. The NFP Program's enabling services address workforce participation, family violence, childhood injuries, substance abuse, as well as preventive health practices such as healthy nutrition, infant health and development, and optimally spaced pregnancies. The MCH-NFP program capacity includes a program manager, clinical director, contract monitor, and a nurse consultant for every 5-6 teams of 9 NFP nurses per team. NFP has become MCH's largest single investment due to the proven effectiveness of this intervention.

MCH staff and contracts dedicated to preventive and primary care for pregnant women, mothers and infants include Maternal Health Medical Director, Nurse Consultant, Health Communication Coordinator, four Epidemiologists, two program managers, nine regional nurse coordinators of the Fetal Infant Mortality Review program and a contract for the social marketing campaign Partners for Healthy Babies. Other contracts include Healthy Start agencies and Office of Addictive Disorders. Infant Mortality Reduction Initiatives (IMRI) were established by MCH in each of the 9 regions of Louisiana, including a staff person to coordinate and direct Fetal-Infant Mortality Review with a Case Review Team made up of public and private obstetric and pediatric providers and a Community Action Team made up of local community leaders. The IMRIs have become the regional maternal and infant health infrastructure that conducts needs assessment, strategic planning, and implementation of preventive interventions. DHH has funded a new Birth Outcomes Initiative. MCH will work in close collaboration with this initiative to add pre and interconceptional health and late preterm birth prevention approaches to addressing Louisiana's high infant mortality rate.

Screening, brief intervention and treatment of pregnant women for alcohol use, substance use, tobacco use, depression, and domestic violence offers opportunity for improved outcomes. In response, MCH collaborates with the Louisiana Office of Addictive Disorders (OAD) and Office of Mental Health (OMH) to implement and evaluate a screening and treatment program for pregnant women of Louisiana. Other partners include Louisiana Medicaid, and American College of Obstetricians and Gynecologists -Louisiana Section, and March of Dimes. OPH WIC sites provide SBIRT services. A small proportion of private clinics and providers participate in the SBIRT program. Efforts are underway to initiate a Pay for Performance to encourage private Medicaid providers to participate.

MCH addresses gaps in smoking cessation services for perinatal populations through a jointly funded initiative with the Louisiana Tobacco Control Program and Louisiana Public Health Institutes' Tobacco Free Living program.

MCH staff and contracts dedicated to preventive and primary care services for children including injury prevention consist of a Child Health Medical Director, two program managers, nine regional Child Safety Coordinators, three injury prevention program managers, two epidemiologists, over 100 Nurse Family Partnership nurses, and a contract for social marketing campaign addressing safe sleep environments for infants. The MCH Program provides funding for a State level Child Safety Coordinator who works to decrease unintentional injury-related morbidity and mortality of children ages 0-14 years, and Sudden Infant Death Syndrome (SIDS)-related deaths. The MCH Regional Child Safety Coordinators, who are certified in injury prevention through the University of Delaware, coordinate community-based systems of unintentional injury prevention initiatives in

the 9 OPH regions of the state to address the leading causes of unintentional injury-related mortality and morbidity of children under 15 years of age. As Nationally Certified Child Passenger Safety Technicians, these Coordinators perform motor vehicle child restraint inspections to ensure that children ages 0-16 years are properly restrained. As certified Louisiana Child Care Health Consultants, the Child Safety Coordinators provide to child care center staff the child safety training needed to obtain or maintain their child care center licensure with the Department of Social Services. The coordinators work collaboratively with the Office of Public Health's Injury Research Prevention Program and with Emergency Medical Services for Children (EMSC) to deliver injury preventive services in their communities.

The MCH Program provides the staff support for the 25-member State Child Death Review Panel, which is legislatively mandated to review unexpected deaths of children 14 years of age and younger, including SIDS. The State Panel makes mortality prevention recommendations to the Legislature. Louisiana Child Death Review has incorporated into its process the National Center for Child Death Review's recommendations for effective reviews. Louisiana Child Death Review has worked to establish linkages with local coroners, law enforcement, fire departments, child protective services, emergency medical services, and other professionals involved in the investigation of sudden unexpected infant and child deaths to use the CDC Sudden Unexpected Infant Death Investigation Reporting Form to standardize and improve data collection at infant death scenes. The Panels also use the National Center for Child Death Review's data reporting for case reviews to promote consistent diagnosis and reporting of the findings of infant and child deaths. MCH provides outreach and training of the coroners, death scene investigators, and first responders on recommended death scene investigation procedures to better determine causes of death of infants who die suddenly and unexpectedly.

The Child Care Health Consultant Program begun by MCH provides certification-based training for public and private health and safety professionals to become Louisiana Child Care Health Consultants. The training is based on child care standards from the Second edition of Caring for Our Children's National Health and Safety Performance Standards. The Child Care Health Consultants provide the mandated health and safety trainings to out-of-home child care centers and early education facilities.

BrightStart is Louisiana's Early Childhood Comprehensive Systems Grant Initiative, which is a framework for service systems integration and partnerships. To maintain this framework, BrightStart functions under the auspices of the Louisiana Governor's Children's Cabinet and the Advisory Board, with the MCH Program providing administrative support and direction for the management of the grant initiative. Two contract coordinators oversee all activities of the grant that are carried out by the 5 workgroups addressing medical home, parenting education, family support, early care and education, and social-emotional health.

To improve Louisiana's low breastfeeding rate, MCH funds The Gift, a program to certify hospitals as breastfeeding-friendly facilities if they comply with a list of breastfeeding related policies and activities. Educational materials, training, and incentives are included in this intervention. The MCH Nutrition Consultant participates with the Louisiana Obesity Council and is the co-chair of the council subcommittee Louisiana Action for Healthy Kids (LA AFHK). LA AFHK addresses the epidemic of childhood obesity by focusing on changes in schools to improve nutrition and increase physical activity. MCH will implement a childhood obesity prevention program, Nutrition and Physical Activity Self- Assessment for Child Care program, an evidence-based program designed to enhance policies, practices, and environments in child care settings by improving the nutritional quality of food served, the amount and quality of physical activity, staff-child interactions, and the facility nutrition and physical activity policies and practices and related environmental characteristics. MCH will also collaborate with Louisiana Department of Social Services to ensure Louisiana childcare licensure regulations include strong nutrition and physical activity policies.

The Adolescent and School Health Program staff and contracts include a Program Manager, five

Contract Monitors, a data manager, and contracts for operation of School Based Health Centers statewide. The 27 members of the School-Based Health Center (SBHC) Sponsor Network engage in infrastructure building through participation on medical, behavioral health, and administrative subcommittees of the Network. These subcommittees assist the central OPH office in formulating policy related to best practices and standards of care for medical and behavioral health services in SBHCs. The SBHC Sponsor Network has been involved in changing laws related to including protection for nurse practitioners and physician assistants within minor consent law language and advocacy efforts at the state and national level for increased funding for SBHCs. As part of its efforts to build infrastructure, OPH certifies non-OPH funded entities to enroll as Medicaid providers based on an evaluation of that entity's adherence to OPH/ASHP standards of care for SBHCs. OPH petitioned Medicaid at both the state and national level to permit Medicaid reimbursement for behavioral health services provided in SBHCs.

MCH staff and contracts dedicated to oral health include two program managers, an epidemiologist, a health educator, fluoridation engineer, an Oral Health Advisory Council, and contracts for dentists and dental hygienists to apply dental sealants in elementary schools, for 2nd and 6th grade students in schools where over 50% of students are eligible for a free or reduced lunch. The school-based sealant program conducts preliminary dental screenings by a dentist and then applies sealants on appropriate teeth.

The state mandated Newborn Screening and Follow-up Program ensures that all newborns are screened before discharge from the hospital and at greater than 24 hours of age. The newborn screening battery consists of 28 tests, as recommended by the American College of Medical Genetics. For infants with abnormal tests, Genetics Program staff assist the primary medical provider to ensure timely and appropriate confirmatory testing and if necessary, treatment. The Genetics Program follows patients until their diagnosis is confirmed. Contracts with three Louisiana medical schools provide confirmatory laboratory testing and specialized treatment for these patients.

MCH provides supplemental funding to the OPH Family Planning Program, which provides comprehensive medical, educational, nutritional, and family planning services to adolescents and adults. The Family Planning waiver was implemented in Louisiana October 2006. MCH also supplements the OPH Immunization Program funding.

The development of information systems that are capable of providing timely and appropriate data for planning and evaluation of programs and policies is a key component of MCH. The Epidemiology, Assessment, and Evaluation (EAE) unit within the MCH Program is composed of a CDC assigned MCH Epidemiologist, a State Systems Development Initiative (SSDI) Coordinator/ senior MCH Epidemiologist, a Needs Assessment Epidemiology Coordinator, a Louisiana Pregnancy Risk Assessment Monitoring System (PRAMS) Coordinator, a PRAMS Operations Assistant, and various interns and graduate master level students of Tulane and LSU schools of public health. The EAE unit holds ultimate responsibility for facilitating access to, analyzing, and translating program-relevant data. The unit conducts epidemiological studies; Block Grant data analysis and translation; objective data preparation for policy-building process and other specific projects; analyses of data from national and state-based data. Ongoing agreements are in place to obtain annual data files from Louisiana sources, including vital records (births, deaths, fetal deaths, and inpatient hospital discharge), Medicaid eligibility files, WIC eligibility files, newborn screening data, and birth defects surveillance data.

The MCH and CSHCN epidemiologists work with program coordinators, providers, and other stakeholders to share information obtained from the analysis of surveillance system data, linked data sets, and other MCH relevant surveys, and to seek program input on the policy implications of the findings. The MCH EAE unit works closely with internal partners at the Department of Health and Hospitals (DHH) to establish and improve linkages between vital records surveillance files and the MCH related databases.

The Louisiana SSDI program focuses on increasing the data/epidemiologic capacity of Louisiana's MCH and CSHCN programs to monitor and address MCH health problems. The project improves data linkages and surveillance systems outlined in the Title V Block Grant Health System Capacity Indicator #9A. Access to existing and newly acquired data sets and information provided by their analyses and linkages allow MCH and CSHCN Programs to identify priority needs through needs assessment processes, report on national and state performance measures, target resources, and develop and evaluate programs. The joint effort between epidemiologists and program staff help develop future interventions for these programs as well as assess their respective National and State Performance Measures.

From the linked data, surveys, and registries, MCH epidemiologists conduct studies that provide relevant information to program staff and policy makers in order to develop interventions that will help the state to meet national and state performance targets. EAE unit analyses and results are disseminated at the state and local levels in the form of: 1) presentations to the State Perinatal Commission, internal and external meetings and conferences, 2) publications, such as peer reviewed journals, the Louisiana State Medical Society Journal, Baby Talk Newsletter, and The Louisiana Morbidity Report, 3) data and information on the state intranet and internet sites.

EAE collects Louisiana-specific, population-based data on maternal attitudes and experiences before, during, and shortly after pregnancy. The Louisiana Pregnancy Risk Assessment Monitoring System (LaPRAMS), which began in Louisiana in 1997, provides data for planning and assessing health programs and for describing maternal experiences that may contribute to maternal and infant health. Findings from LaPRAMS are used to enhance the understanding of maternal behaviors and their relationship with adverse pregnancy outcomes and aid in the development and assessment of programs designed to identify high-risk pregnancies and reduce adverse pregnancy outcomes.

EAE provides the race specific data that help target resources to the highest risk populations. To enhance cultural competence among its service providers and administrative staff, Nurse Family Partnership Program, Child Care Health Consultants, FIMR and Child Safety Coordinators, MCH provides trainings which increase self-awareness to inter-personal attitudes and behaviors as well as an understanding of cultural, racial, economic, and linguistic challenges encountered by MCH populations. Prior to implementing MCH health education strategies, formative and evaluative research is conducted with consumers to receive feedback on specific messages and to test relevance, appropriateness, and effectiveness of campaigns and materials. The campaigns and materials are simultaneously developed, produced and printed for Spanish-speaking audiences. Effective messages targeting African American women are of particular importance in reducing the racial disparities seen with SIDS and preterm births. DHH offers language translation services to public health unit clients and offers online and paper Medicaid enrollment and educational information in Spanish and Vietnamese.

The CSHS program provides family-centered, comprehensive, coordinated services for CSHCN through regionally based subspecialty clinics, including rehabilitation services for CSHCN who receive SSI Disability benefits. Clinics are staffed with contracted subspecialists, nurses, social workers, social service consultants, nutritionists, and audiologists. The increase in Medicaid coverage through LaCHIP, LaCHIP Affordable Plan, and new Medicaid programs for children with disabilities, including the Medicaid Purchase plan and the Family Opportunity Act, have increased access to care through the private sector for many CSHCN. As a result, the number of CSHCN coming to CSHS clinics has decreased rapidly until recently. In 2009, the number increased slightly with 4515 CSHCN receiving 20,780 visits/encounters. Although 91.2% of Louisiana CSHCN have health insurance, the shortage of Medicaid providers in the state has limited access to primary and subspecialty care for many CSHCN. Therefore, CSHS continues its regional subspecialty clinics to address these shortages. 98% of CSHCN in CSHS clinics are linked to medical homes (MHs).

In addition to subspecialty clinics, the Hearing, Speech and Vision (HSV) program provides

audiology evaluation and hearing aids in CSHS clinics and infant and toddler hearing and speech screenings in MCH clinics in Regions IV and V. Both clinics coordinate with the Newborn Hearing Screening Program, the Part C Early Intervention Program (Early Steps), and the Parent-Pupil Education Program (PPEP) of the School for the Deaf. In 2009 the program provided 820 audiology evaluations and 569 infant and toddler screenings and dispensed 147 hearing aids. Access to private audiologists has greatly improved with increased insurance coverage, but shortage areas exist. The number of program audiologists decreased to two for the entire state in 2009. The audiologist in Region IX will be promoted to HSV Program Manager when the current program manager retires at the end of June, and children served in Regions II, VI and IX transitioned to private sector clinics. Audiology consults in Region VII will be handled by LSU Shreveport.

The HSV program also provides training for vision screening. In 2009 two contracted vision specialists trained over 1,020 school nurses, daycare providers, Head Start providers, preschool providers and volunteers to do preschool and school vision screening using Titmus testing and photo-screening. The Louisiana Lions Cubsight Program, supported by HSV funds, screened over 19,000 preschool children using photo-screening.

Another shortage area addressed by the CSHS program is dental care. CSHS funds a CSHCN dental clinic in Region I with services provided by LSU School of Dentistry. CSHS also provides assistance through its regional offices for CSHS eligible children without Medicaid to access dental care in the private sector.

CSHS has two newborn screening programs: the Universal Newborn Hearing Screening Program and the Louisiana Birth Defects Monitoring Network (LBDMN). In 2009 over 97% of newborns were screened for hearing loss before hospital discharge. The program coordinates with private audiologists, Early Steps, and the PPEP to ensure that infants receive early intervention by six months of age, as per AAP guidelines. Health literacy sensitive brochures in English and Spanish are distributed to birthing hospitals to encourage follow-up. Brochures will also soon be available in Vietnamese as well.

The LBDMN is an active surveillance system that was mandated without funding in 2001. Data collection began in 2005 for 40% of births and in 2009 covered 80% of births. In 2010 the program was awarded a $947,403 CDC five year grant for statewide expansion and further development of its database. The LBDMN Program Manager resigned in December 2009 and a new Program Manager with experience in surveillance systems and clinical medicine was hired in June 2010. The program will be statewide by the end of 2011.

CSHS provides comprehensive care coordination in CSHS subspecialty clinics. A new web-based care coordination program in CSHS clinics focuses on youth in transition to encourage self-determination and independence. This has been piloted in regions 1 and 6 and is ready for statewide expansion over the next few years. Care plans for CSHCN with complex needs are mailed to PCP's.

Two statewide CSHS parent consultants advise on all CSHS policies and program decisions to ensure that services are family-centered, and work with Families Helping Families (FHF) to hire, train, and supervise parent liaisons (PL's) for CSHS clinics. PL's are paid parents of CSHCN who receive in depth leadership training to provide parent to parent support. They also work with CSHS staff to identify culturally appropriate services for the diverse population served in CSHS clinics. PL's have also provided community programs on cultural diversity. In June 2010, 12 new PL's graduated from the "Parent Leadership Skills Training." F2F HICS provide region specific resource consultation for PL's statewide.

CSHS is part of a DHH-DSS data integration project to make services easier to use. The goal is to create a master patient database of clients served by the two agencies. The database will indicate which programs clients are linked to and which programs they are eligible for. When

completed, it will provide CSHCN families with single point of entry into public health programs.

CSHS has a new CSHS stakeholder group composed of program managers from DHH and DSS programs that serve CSHCN as well as representatives from FHF and Family to Family Health Information Centers (F2FHICs). The purpose of the stakeholder group is to improve collaboration between programs. CSHS will contract with FHF to provide in-services for public health program staff at the regional level to foster referral between programs.

CSHS has had MH initiatives since 2000 to increase the MH capacity of PCP's. CSHS works with the Louisiana American Academy of Pediatrics (AAP) chapter and the Louisiana Academy of Family Practice (LAFP) to increase the MH capacity of its members. The 2010 Needs Assessment Physicians Survey provided valuable information regarding gaps in knowledge and practice of providers serving CSHCN in the community, which will be used for future education and training activities. CSHS provides articles for the academy newsletters to improve physician awareness of various MH issues. Physician survey questions addressing cultural competence among PCP's did not reveal any specific areas of weakness, however NS-CSHCN survey questions did indicate a greater proportion of non-Hispanic Black than white CSHCN families felt that providers sometimes or never spent enough time with them and did not listen carefully. Data also indicate that non-Hispanic Blacks were less likely to have a usual source of care, and that CSHCN with a MH were more likely to say their doctor always listened carefully and to receive transition services. Therefore, CSHS will work to link all CSHCN, and in particular non-Hispanic Black CSHCN, with MHs.

CSHS provides financial incentives for practices to designate a culturally competent care coordinator in the practice and work with CSHS for technical assistance. In 2009 a statewide care coordinator supervisor was hired for this program. A successful model for care coordination in MHs has been implemented in five practices and will be expanded, giving priority to teaching practices and large Medicaid practices. In 2009 the program added a care coordinator to two LSU teaching practices. One was opened to address healthcare needs of Spanish speaking families who have moved into the New Orleans area since Hurricane Katrina. CSHS provides a bilingual, Latino care coordinator for this clinic.

In addition to MHs, in 2009 CSHS collaborated with the diabetes clinic at Children's Hospital and the Tulane cystic fibrosis clinic, both in Region 1, and NICU follow-up clinics in Regions 2 and 7. CSHS funding is used to ensure that clinic staff is adequate to provide comprehensive, coordinated care. When the staff to patient ratio was increased, the diabetes clinic was able to demonstrate a decrease in average Hgb A1C for clinic patients, indicating improved long term diabetes control. The total number of CSHCN served in non-CSHS clinics that receive CSHS funding was 5776 for 2009 for a total of 10,291 CSHCN served.

CSHS works with the two medical schools in the state, Tulane and LSU, to ensure that all pediatric residents are trained in MH. The CSHS Director is responsible for coordinating the developmental rotation for both schools. The CSHS Statewide Care Coordinator Supervisor gives a monthly didactic session on MH (MH), and residents are required to do a MH case presentation demonstrating understanding of community and public health resources. Residents participate in "Operation Housecall" where they conduct a structured family interview during a CSHCN home visit to increase their sensitivity to families. Residents work with the CSHS funded care coordinator in their continuity clinic MH's to link patients to community resources.

CSHS is represented on Louisiana's Healthcare Quality Forum (LHCQF) MH Committee. This is the legislated stakeholder group to advise administration on healthcare reform initiatives. Through this committee as well as direct meetings with Medicaid, CSHS is able to advocate for improved receipt of MH services, including care coordination, for CSHCN. LHCQF has adopted the NCQA MH criteria for Louisiana. Through a HRSA Primary Care Stabilization Grant, 37 clinics became NCQA certified. DHH has submitted a waiver to CMS for a new managed Medicaid system of Care Coordination Networks (CCN's). Networks would be required to provide

comprehensive care based on the MH model using a capitated reimbursement based on risk. The waiver was submitted in December 2008 and is still pending CMS approval. CSHS will continue to monitor access to services for CSHCN as healthcare reform initiatives are implemented.

The following State statutes are relevant to the Title V program:
1. LSA-R.S. 46:971-973 - Administration of MCH Services in State of Louisiana - Health Department Responsible
2. LSA-R.S. 17:2111-2112 - Vision and hearing screening - Health Department and Department of Education Responsible
3. LSA-R.S. 33:1563 - SIDS autopsy; reporting to Health Department Required
4. LSA-R.S. 40:1299 - Mandated Genetics - Newborn screening - Health Department Responsible
5. LSA-R.S. 40:1299.111-.120 - Children's Special Health Services - Health Department Responsible
6. LSA-R.S. 40:5 - State Board of Health authority to create MCH & CC Agency
7. LSA-R.S. 40:31.3 - Adolescent School Health - School Based Clinics - Health Department Responsible
8. LSA-R.S. 46:2261 - The Identification of Hearing Impairment in Infants Law - Health Department Responsible
9. LSA-R.S. 40:31.41-.48 -- The Births Defects Monitoring Network -- Health Department Responsible
10. LSA-R.S. 40:2019 -- Child death investigation State Child Death Review Panel

2008 Senate Concurrent Resolution 83
To urge state agencies which participate in BrightStart, formerly known as the Early Childhood Comprehensive Systems initiative, to coordinate policy, budget planning, and services that support early childhood development.

2008 Senate Concurrent Resolution 70
To urge the Nurse-Family Partnership Advisory Council and Department of Health and Hospitals to study the expansion of Nurse-Family Partnership program and to report to the House and Senate committees on health and welfare.

2009 House Concurrent Resolution 226; Senate Concurrent Resolution 113
To urge and request BrightStart, an interagency collaboration, to establish the Home Visiting Advisory Council in preparation for potential new federal funding of home visiting programs.
An attachment is included in this section.

C. Organizational Structure

The Department of Health and Hospitals is one of twenty two departments under the direct control of the Governor. The State Health Agency, the Office of Public Health is one of the five major agencies within the Department of Health and Hospitals (DHH). The State Medicaid Agency, Bureau of Health Services Financing, is also located in this Department as well as the Office of Mental Health, Office of Addictive Disorders and the Office for Citizens with Developmental Disabilities. The Office of Public Health is organized into five centers, Center for Preventive Health; Center for Environmental Health; Center for Records and Statistics; Center for Community Preparedness; and Center for Community Health. The Title V programs, the Maternal and Child Health Program and Children's Special Health Services, are located in the Center for Preventive Health in the Office of Public Health, along with Family Planning, Nutrition, Genetics, Lead Poisoning Prevention, Speech and Hearing, Oral Health, Tuberculosis Control, Immunization, Sexually Transmitted Diseases and HIV/AIDS, and Adolescent and School Health Programs. The organizational charts in Figure 1 of the attachment illustrate the structure of the departments under the Governor, DHH, Office of Public Health, Center for Preventive Health, MCH, and CSHS.

The Children's Cabinet in the Office of the Governor provides a monthly forum for the Secretaries of the child serving departments to meet and address the needs of children in Louisiana. The Children's Cabinet Advisory Board consists of the Assistant Secretaries of the agencies within the departments that serve children, as well as non-profit and advocacy organizations. This Board meets monthly and makes recommendations for policy, program development, and funding for child issues. MCH is represented on subcommittees of the Board. The Early Childhood Comprehensive Systems grant is being administered as a joint project of the Children's Cabinet and the MCH Program.

The MCH and CHSCN Program and Medical Directors are the individuals primarily responsible for administering the programs funded by Title V. These staff report to the Director of the Center for Preventive Health, who in turn reports to the Assistant Secretary of OPH. The Directors of the Family Planning, Immunization, Genetics, Oral Health, and Adolescent and School Health Programs are responsible for the proper administration of the Title V funds allocated to these programs and provide to the Title V Director annual reports and plans related to their particular performance measures.

The MCH Program is organized by population and functional areas including Maternal Health, Child Health, Nurse Family Partnership, Epidemiology, and Health Education/Communication. The Team Leaders for each of these areas as well as the MCH Nutritionist and Assistant MCH Administrator meet with the MCH Director every month for a MCH Management Team meeting to foster collaboration among these programmatic and functional areas and to keep the MCH Director and each other informed. Each of the Team Leaders meets with their core team 1-2 times per month. The Maternal Health Team includes a Perinatal Director, Medical Director, MCH Health Education/Communication Coordinator, MCH Nutritionist, Maternal Health Program Monitor, Maternal Health Epidemiologist, and CDC assigned MCH Epidemiologist. The Child Health Team consists of a Medical Director, Child Health Educator, Child Safety/Child Death Review Coordinator, Child Health Epidemiologist, MCH Nutritionist, Mental Health Consultant. The Health Education/Communication (HEC) Team includes the HEC Coordinator, Child Health Educator, Child Safety/Child Death Review Coordinator, Nurse Family Partnership Health Educator, Oral Health Educator, Breastfeeding Health Educator, PRAMS Epidemiologist, and MCH Nutritionist. The Epidemiology consists of the 4 epidemiologists listed in the other Teams. The Nurse Family Partnership Team consists of a Program Manager, Clinical Director, State Nurse Consultant, Contract Monitor, and 2 Regional Nurse consultants. MCH conducts a bi-monthly continuing education and program update meeting for all MCH and related staff.

The Regional Infant Mortality Reduction Initiative coordinators meet quarterly. The Regional Child Safety Coordinators meet monthly via teleconference and meet face-to-face quarterly with state MCH Child Safety leadership. Facilitated by these Regional Coordinators, health status information is shared with local public and private health and community leaders in an effort to engage stakeholders to partner with MCH to improve the maternal, infant, child, and adolescent morbidity and mortality rates. State MCH staff provides technical assistance and consultation to help local stakeholders in assessing needs and developing plans to address the needs.

The state is divided into nine administrative regions (see Map 1), with OPH Regional Directors in each of the regions responsible for identifying and addressing the health needs of the population, assuring the quality of care, and providing monitoring and reporting of MCH services delivered through parish health units and contracts. State MCH Medical Directors and Perinatal Nurse Consultants are responsible for the quality of the prenatal services funded by MCH. Each contract funded by MCH has an MCH staff member responsible for ongoing performance monitoring. The Nurse Family Partnership (NFP) team meets quarterly with the supervisors of the OPH and contract sites and conducts annual site visits and training with all NFP nurses. Program and contract monitoring consists of monthly review of fiscal information and performance indicators; and quarterly to annual on-site meetings with contract agencies to determine the quality of the service. Training and technical assistance is provided on a regular basis by MCH staff.

The CSHS central office staff are organized into three programs, with the CSHS Medical Director overseeing all three. The programs are CSHS, Hearing Speech and Vision (HSV), and the Louisiana Birth Defects Monitoring Network (LBDMN). The three programs share two budget and contracts personnel, a Nurse Consultant, and an Administrative Assistant. The CSHS and HSV programs have their own epidemiologists. The LBDMN will contract with LSU for an epidemiologist in 2011, giving each program their own epidemiologist. CSHS collaborates with the MCH epidemiology section for epidemiology technical assistance as needed. The CSHS Executive Staff including the Director, the three Program managers, the CSHS Nurse Consultant, the Social Worker, and CSHS epidemiologists meet frequently to discuss regional issues, software system development and integration, billing issues, budget issues, and other topics of joint concern. CSHS holds staff meetings for all central office staff quarterly and as needed. Each program manager holds regular staff meetings for their program staff as needed. CSHS staff attend the MCH "Issues and Approaches" meetings to provide opportunities for updates and collaborative activities between CSHS and MCH programs.

The CSHS Program central office management team consists of a the Program Manager, Nurse Consultant, Social Work Consultant, Parent Consultant, Epidemiologist, and CSHS Nutritionist, who is shared with MCH. These staff make periodic visits to regional clinic sites to offer technical assistance and to gain input for program planning. CSHS regional clinic staff including nurses, social workers, social service counselors, nutritionists, audiologist, speech pathologist, and clerical staff receive direct supervision from Regional Administrators and/or Regional Medical Directors, and program supervision from CSHS central office staff. The Social Work Consultant supervises the Care Coordinator Supervisor, who is a nurse and a certified case manager contracted through LSU. They make periodic visits to pediatric practices to oversee care coordination contracts and to provide technical assistance to practices. The CSHS Nurse Consultant organizes an Annual Nurse Conference to train new CSHS nurses to work in CSHS subspecialty clinics. The conference frequently is used to provide updates and opportunities for collaboration for CSHS social workers and other field staff as needed, depending on current CSHS initiatives.

The HSV central office management staff consists of the Program Manager, Epidemiologist, Follow-up Coordinator, and Parent Consultant. They are assisted by the Statistical Technician and Administrative Assistant. Additional statewide staff for the newborn hearing screening program include the Newborn Hearing Program Coordinator (audiologist located in Region IV), the HSV Systems Development Coordinator (deaf educator located in Region 1), and the Tracking Specialist (early interventionist located in Region VI). An audiologist in Region IV provides audiology services for CSHS clinics, primarily in Regions IV and V. The program's only speech pathologist, located in Region IV, is retiring this year. Her services will be replaced by a contracted agency. The HSV Program Manager is retiring this year and will be replaced by the audiologist in Region IX.

The LBDMN central office management staff consists of the Program Manager and the Program Monitor (or Family Resource Guide Coordinator). A contracted Epidemiologist and a Coding Specialist will be added in FY 2011. Regional Data Collection Specialists (DCS's) are located in the Parish Health Offices in regions I, II, IV, V, and VII. They extract data from birthing hospital medical records in all regions listed plus Region IX. Two new DCS's will be added in Regions III and VI in FY 2011. The LBDMN Program Manager resigned in December 2009. A new Program Manager was hired in June 2010 who is a physician with disaster surveillance system expertise. ***An attachment is included in this section.***

D. Other MCH Capacity

The State MCH Program staff that provides program planning, implementation, and evaluation includes a MCH Program - Title V Director, MCH Assistant Administrator, Maternity Program Medical Director (60% Full-time Equivalent -FTE), Perinatal Health Director (100% FTE),

Maternal Health Program Monitor (100% FTE), Maternal Smoking Cessation Coordinator (100% FTE - 36% funded by MCH), Child Health Medical Director (100% FTE), Child Safety/Child Death Review Coordinator (100% FTE), Child Health Program Health Educator (100% FTE), Early Childhood Comprehensive Systems (ECCS) Coordinator (37% FTE), ECCS Associate Coordinator (50% FTE), Mental Health Coordinator (90% FTE), MCH Nutritionist (50% for MCH and 50 % CSHS FTE),Hospital Breastfeeding Initiative Coordinator (100% FTE), MCH Health Education Coordinator (75% FTE), Nurse Family Partnership (NFP) Program Manager (100%), NFP Clinical Director (53%), NFP State Nursing Consultant (100% FTE), 2 NFP Regional Nursing Consultants (100% FTE each). A contract for NFP training includes 36% FTE. MCH clerical support includes an MCH Contract Coordinator and an Administrative Assistant. MCH staff providing data analysis include CDC assignee MCH epidemiologist (100% FTE), Child Health Epidemiologist (100% FTE), Maternal Health Epidemiologist (100% FTE), Pregnancy Risk Assessment Monitoring System (PRAMS) Epidemiologist-Coordinator (100% FTE), and a PRAMS Data Manager (100% FTE). A PRAMS contract funds surveys conducted by phone. MCH has a contract with Tulane University School of Public Health for a 5% FTE biostatistician. MCH has been assigned a epidemiology fellow from the Council of State and Territorial Epidemiologists and an intern from the Graduate Student Internship Program. A contract with the National Training Institute provides data management, analysis, and reports for the SBIRT Program (Screening, Brief Intervention, Referral, and Treatment).

The CSHS Program staffing includes a CSHS Program Title V Director, CSHS Nursing Consultant, CSHS Social Work Consultant, CSHS Statewide Parent Training Coordinator, and Parent Consultant, CSHS Statewide Care Coordinator Supervisor, CSHS Nutritionist, Hearing, Speech, and Vision (HSV) Program Director, HSV Follow-up Coordinator, Newborn Hearing Screening Statewide Parent Consultant, Newborn Hearing Screening Statistical Technician, two contracted Vision Specialists, two CSHS accounting and contract monitoring staff, two CSHS clerical staff, a Louisiana Birth Defects Monitoring Network (LBDMN) Program Manager, and a LBDMN Program Monitor. Through HSV MCH and CDC grants, HSV Newborn Hearing Screening Program has a Statewide Program Coordinator, a Statewide Tracking Specialist, and a Statewide Systems Development Coordinator.

CSHS Program staff providing data analysis include a CSHS epidemiologist, a Newborn Hearing Screening program Epidemiologist, and a LBDMN Epidemiologist (to begin in 2010). The CSHS epidemiologists receive technical assistance from the MCH epidemiology section.

The Adolescent and School Health Program staff includes a Program Manager, 4 Program Monitors, a Data Manager, and Administrative Assistant. The Oral Health Program staff includes a Program Manager, Fluoridation Engineer, Health Educator, Epidemiologist and a vacant Dental Director position. The Injury Prevention Program will become part of MCH in July 2010 and includes a program manager, 2 health educators, 2 epidemiologists, a contract monitor, and an administrative assistant.

In each of the 9 Department of Health and Hospitals administrative regions, the Office of Public Health has a Regional Administrator, a Medical Director, Nurse Consultant, Administrative Manager, Social Worker, and Nutritionist responsible for the planning, implementation, monitoring and evaluation of public health services in their respective regions. Working under the direction of the Regional Medical Director, MCH contracts for 9 Child Safety/Child Death Review Coordinators (100% FTE each) and 9 Infant Mortality Reduction Initiative RNs (50-60% FTE each). Regional CSHS Staff for all nine regions include 24 nurses, 14 social workers, 1 social service consultant, 13 parent liaisons, 2 audiologists, 1 speech pathologist and 16 clerks. These 74 CSHS staff are the equivalent of 32 FTE, since with the decrease in staff due to budget cuts, regional staff are frequently "cross-trained" to work in several programs. Although policy development and programmatic direction are provided by the State MCH Program staff, regional and local staff provide significant input. In addition, CSHS contracts with 74 subspecialty physicians who conduct monthly or bi-monthly CSHS clinics. Other regional staff not included in parish health unit operations include 9 Newborn Screening Regional Task Force Leaders and 5

Birth Defects Data Collection Specialists. CSHS also contracts with a social worker, an occupational therapist, and a Spanish speaking care coordinator to be full time care coordinators for 2 large pediatric practices, one of which is a key teaching practice for pediatric residents.

The number of OPH Parish Health Unit staff (FTEs) funded by the MCH to provide preventive pediatric services, prenatal care; pregnancy testing; and prenatal screening, brief intervention, referral to treatment for substance abuse, mental disorders, and intimate partner violence is 27 FTEs, plus 124 FTE Nurse Family Partnership home visiting nurses hired by OPH.

To enhance MCH capacity, staff has been added at the parish or regional level through contract agencies. Contracts have been used increasingly because there is a strict limit on the number of state employees that can be hired. In the four Healthy Start projects, MCH has supplemented those programs with funding for enabling services such as outreach and case management (4 FTEs), or infrastructure including Fetal-Infant Mortality Review or Program Management (.85 FTE). In addition to the OPH staff working in NFP, another 91 positions are hired through contracts in each region of the state. Contracts for prenatal providers and support staff in areas with access problems fund approximately 5.5 FTEs. Mental health professionals are hired to provide maternal, infant and early childhood mental health services through contracts with social service agencies in Baton Rouge region, Lake Charles, New Orleans metropolitan area, and Monroe region (4.25 FTEs). MCH funds an FTE in 2 of the 9 regional Screening, Brief Intervention, Referral, and Treatment program for maternal substance abuse, mental illness, and intimate partner violence. The state Office of Addictive Disorders funds the other 7 regional coordinators. MCH has contracts to operate the toll-free information and referral line as well as the social marketing campaigns promoting early prenatal care, pre/interconceptional health, and safe sleep environment for infants. In the coming year a contract with Louisiana State University School of Public Health will hire 1.4 FTEs to implement an early childhood obesity prevention program in childcare centers.

Please refer to the attachment for brief biographies of the MCH Senior Level Management Team (Table 1).

The MCH Management Team consists of the Maternity and Child Health Medical Directors, Director of Perinatal Health, MCH Program Director, Assistant MCH Administrator, MCH Epidemiologist, Nurse Family Partnership Director, MCH Nutritionist, and Health Education/Communication Coordinator. Management Team meetings are held monthly. A Maternal Health Medical Consultant will be hired to lead MCH's pre/interconceptional health initiatives.

The CSHS Management team consists of the CSHS Director, the CSHS, HSV and LBDMN Program Managers, the CSHS Nurse Consultant, the CSHS Social Worker Consultant, the CSHS Epidemiologist, and the CSHS contracts and budget person. The team meets frequently throughout the month. All CSHS central office staff meet quarterly.

CSHS has CSHCN parent involvement at all levels. Thirteen parent liaisons contracted from Families Helping Families attend all CSHS clinics and participate on Care Coordination teams to provide parent to parent support and to link families with community resources. A 14th parent has been hired for HSV. All parents are supervised by the statewide CSHS Parent Consultant (PC) and the Parent Training Coordinator, who hold annual in depth trainings for parent liaisons that span several days over a three month period of time. The PC participates in central office executive staff meetings and is consulted on all CSHS policies and program activities.

An attachment is included in this section.

E. State Agency Coordination

The Maternal and Child Health (MCH) Program has a long history of extensive coordination with public and private agencies and organizations serving reproductive age women and children. The State Title V Maternal and Child Health Program is housed in the Office of Public Health (OPH), Department of Health and Hospitals (DHH). The other agencies under the Department include the Office of Mental Health, Office for Citizens with Developmental Disabilities, Office of Aging and Adult Services, and the Office for Addictive Disorders. Other related sections of DHH include the Bureau of Health Services Financing (Medicaid), Bureau of Primary Care and Rural Health, and the Bureau of Minority Health Access.

Personal health services and local public health functions are provided by OPH parish health units (PHU) distributed throughout 62 of the 64 parishes in the state, except in New Orleans and Plaquemines Parish, which have their own independent health departments. PHU WIC patients who receive prenatal or child health care from private providers, receive health counseling, education, and referral from MCH funded staff. Public health nurses and social workers provide a home visit to families that lose an infant to Sudden Infant Death Syndrome (SIDS). The state Title X Family Planning Program receives funding from MCH. In 2006, the Family Planning Waiver began in Louisiana and MCH is conducting the evaluation for this Waiver. Family Planning and MCH Programs are collaborating on a pre/interconceptional health initiative and MCH provides funding for folic acid distribution to Family Planning Program clients.

MCH coordinates with the state Ryan White and Title IV AIDS through joint planning and assessment of the perinatal population. Both programs participate in the regional infant mortality review process (FIMR). MCH has a longstanding collaboration with the OPH-STD program, identifying and reviewing records of infants born with syphilis and HIV, as well as coordinating programmatic aspects of sexually transmitted diseases that impact birth outcomes.

MCH provides funding to the Immunization Program. Shots for Tots, Louisiana's Infant Immunization Initiative, is a network of public and private entities working cooperatively to update and educate parents and providers to ensure the highest level of immunizations possible.

Approximately one-third of the Nurse Family Partnership Program staff is hired through OPH. The remaining staff are hired through contracts and partners with a variety of state and local entities including Louisiana State University Health Sciences Center in New Orleans, Shreveport, Monroe, and Alexandria; Local Governmental Entities in Baton Rouge region, Tangipahoa and Jefferson Parishes; Nicholls State University School of Nursing in southeast Louisiana; Medical Resources and Guidance, Inc.; Southwest Louisiana Area Health Education; and St. Tammany Parish Hospital. Funding for support of NFP has come from community resources including the Institute of Mental Hygiene in New Orleans, Baptist Community Ministries (BCM), and the New Orleans United Way.

The Medicaid Agency, the Bureau of Health Service Financing, and MCH coordinate in program development and data sharing. MCH is a Medicaid provider of EPSDT services, prenatal care, and case management. Local PHU assist pregnant women, family planning patients, and parents with the eligibility process for Medicaid and CHIP. In large PHUs, Medicaid has out-stationed an eligibility worker to expedite applications for pregnant women. MCH provided the data that showed the severe access problems facing the undocumented pregnant women who arrived in Louisiana post-Hurricane Katrina. Medicaid coverage for undocumented pregnant women was implemented May 2007. MCH Nurse Family Partnership Program is a Medicaid Targeted Case Management provider.

Infant Mortality Reduction Initiatives (IMRI) are funded by MCH in each of the 9 regions of Louisiana, including a staff person to coordinate and direct Fetal-Infant Mortality Review with a Case Review Team made up of public and private obstetric and pediatric providers and a Community Action Team made up of local community leaders. Regional coordinators are hired by social service agencies. MCH funds a Fetal Infant Mortality Review (FIMR) nurse through the New Orleans Health Department's Healthy Start Program. MCH provides funding for women with

mental disorders in collaboration with the City of New Orleans Healthy Start program, local human service agencies, Nurse Family Partnership, and Parish Health Units. MCH has contracts with a New Orleans non-profit counseling agency to provide mental health services for children exposed to extreme violence including murder, families with a loss due to Sudden Infant Death Syndrome, and at-risk families with children age 0-5. MCH funds outreach, case management, and FIMR staff in the Baton Rouge, North Louisiana, and Lafayette Healthy Start Programs.

A contract between MCH, the state Office of Addictive Disorders (OAD), and Ira Chasnoff, National Training Institute has been established to develop a statewide system addressing maternal substance abuse. The Screening, Brief Intervention, Referral, and Treatment (SBIRT) Program addresses prenatal substance abuse, mental disorders, and intimate partner violence. The state Office of Mental Health (OMH) is a key collaborator on SBIRT. OMH was awarded a grant for expansion of mental health services in Lake Charles for pregnant and postnatal women including those identified by the SBIRT initiative. The WIC Program provides SBIRT screening of pregnant women. MCH has a memorandum of agreement with the state OAD to provide pregnancy testing and prenatal care referral for women served by OAD. MCH provides the test kits, training, and access to services of the PHU for pregnant women.

Louisiana's Children's Cabinet, established by the legislature in 1998 as a policy office within the Office of the Governor, coordinates policy, planning, and budgeting that affects programs and services for children. It is composed of the Secretaries of the Departments of Social Services (DSS), Health and Hospitals, Public Safety and Corrections, and Labor; the Superintendent of Education; the Commissioner of Administration; a member of the Louisiana Council of Juvenile and Family Court Judges, and a representative of the Office of the Governor, and a representative of the Children's Cabinet Advisory Board. The Advisory Board provides information and recommendations from the perspective of advocacy groups, service providers, and parents. Advisory Board members represent a wide variety of non-profit agencies, health and educational institutions, assistant secretaries from agencies within the Departments listed above, and juvenile court. The Early Childhood Comprehensive System (ECCS) grant is administered as a joint venture between the Children's Cabinet and MCH. Legislation exists that request the following entities work together in the ECCS initiative: Office of Family Support and Office of Community Services (OCS) within the DSS; OPH, Office of Mental Health, Office of Citizens with Developmental Disabilities, Office of Addictive Disorders, and the Bureau of Health Services Financing (Medicaid) within the Department of Health and Hospitals; State Department of Education (DOE) including the Pre-K and Early Childhood Education Programs section; Board of Elementary and Secondary Education; Division of Administration; and Office of Youth Development within the Department of Public Safety and Corrections. An Early Childhood System Integration Budget was written into statute during the 2008 state legislative session, requiring the creation of a budget reporting the spending on children ages 0-5 years in the four early childhood system component areas of ECCS Initiative now entitled BrightStart.

The MCH Program works closely with the Office of Community Services (OCS) within the Department of Social Services (DSS) to prevent child abuse and neglect. A Memorandum of Understanding (MOU) between the agencies exists to provide public health nursing assessments for children under investigation by the Office of Community Services (OCS) for suspected failure to thrive, malnutrition, or other medical neglect. The MCH Program works with OCS' High Risk Infant strategic planning committee to reduce infant morbidity and mortality due to intentional and unintentional injuries. Also, MCH collaborates with the Department of Social Services Child Care Licensing Section and the Office of Public Health, Center for Environmental Health to ensure that child care centers continue to receive the three hours of DHH-mandated health and safety training. The MCH Program works collaboratively with OCS in the promoting awareness of Louisiana's Safe Haven Law, which provides a legal means for parents to safely relinquish custody of unwanted infants up to 31 days of age without the threat of prosecution for neglect, abandonment or child cruelty. DSS provides TANF funding for MCH's Nurse Family Partnership Program.

The Child Death Review Panel, established by the State Legislature in 1993, reviews all unexpected deaths in children under the age of 15. This panel includes representatives from MCH, OCS-Child Protection Agency, Coroners Association, Attorney General's Office, American Academy of Pediatrics, State Medical Society, Vital Registrar, State Police, Fire Marshall, the Legislature and the general public. The MCH Program currently staffs a full time position for the Child Death Review Panel. MCH sponsors trainings on infant and child fatality investigation to educate coroners, death scene investigators, first responders, and stakeholders on conducting death scene investigations in a culturally competent manner consistent with standard protocol. The MCH Program collaborates with the Children's Justice Act (CJA) Taskforce within the Department of Social Services. The Child Health Medical Director serves as a member of the CJA Taskforce, which works to improve the investigation, prosecution and judicial handling of cases of child abuse and neglect, particularly child sexual abuse and exploitation, in a manner that limits additional trauma to the child victim. This also includes the handling of child fatality cases in which child abuse or neglect. MCH serves on Emergency Medical Services for Children (EMSC) Advisory Council. MCH has contracts with a New Orleans non-profit counseling agency to provide mental health services for children exposed to extreme violence including murder, families with a loss due to Sudden Infant Death Syndrome, and at-risk families with children age 0-5.

Collaboration with the Louisiana Chapter of the American Academy of Pediatrics (LA AAP), and contractual partnerships with hospitals, community agencies, and the Louisiana Public Health Institute (LPHI) enable MCH to carry out its child health and safety efforts. MCH contractual partners for the Child Safety Coordinators/Local Child Death Review Panel Coordinators include Children's Hospital in New Orleans, MCH Coalition in Baton Rouge, Options for Independence in Lafourche Parish, Area Health Education Centers of Southeast, Southwest, and North Louisiana, and Christus Cabrini Hospital in Alexandria.

A key provider of MCH services across the state is Louisiana State University Health Sciences Center (LSU-HSC). LSU-HSC administers the services of the 9 state operated hospital located in each region of the state. MCH contracts with LSU-HSC in 4 of the 9 regions to provide Nurse Family Partnership services. LSU provides prenatal care in areas of Shreveport with poor access to private care. The LSU-HSC provides obstetric and mental health expertise and consultation to the MCH Program. Internships for LSU-HSC School of Public Health students are provided in the MCH Program.

Tulane University Health Sciences Center (TUHSC) collaborates with MCH to provide essential services. Evaluation, biostatistics, and health communication expertise is provided through contracts with the TUHSC School of Public Health and Tropical Medicine. Each semester at least 5 MPH students conduct their required internship in the MCH Program. Tulane Department of Psychiatry provides faculty for infant mental health training and technical assistance for the Nurse Family Partnership Program. Tulane provides program coordinators to carry out the efforts of the BrightStart (Louisiana Early Childhood Comprehensive Systems Grant Initiative). The partnership will expand to include a parenting education coordinator of an evidenced-based parenting education model.

The Tulane University MCH Leadership Training grant is carried out in close collaboration with MCH state and local staff.

The MCH Director serves on the State Commission on Perinatal Care and Infant Mortality, standardizing the framework for regionalization of perinatal services by determining the level of hospital services provided. These standards are used by the Hospital Licensing Section and for Medicaid reimbursement. The MCH epidemiologists present findings from birth and infant death and PRAMS data

The child dental sealant program is administered though local schools and in collaboration with Federally Qualified Health Centers and local dentists and dental hygienists. The Fluoridation

Program works with local government agencies to provide education and fund water systems that are initiating community water fluoridation.

CSHS utilized its 2010 Needs Assessment as an opportunity to build new partnerships and enhance state agency coordination. The purpose of this year's Needs Assessment was to capture the existing medical home infrastructure capacity among primary care providers and the coordination of enabling services among CYSHCN stakeholder agencies. As such, three stakeholder groups were identified as key contributors to the process. These were primary care pediatricians and family practice physicians, families with CYSHCN, and representatives from ten government and community programs that provide direct care and coordination of services for Louisiana's CYSHCN and their families. The ten programs represented in the stakeholder group were CSHS, Hearing Speech and Vision (HSV), Early Steps, Supports and Services, Greater New Orleans Resource Centers on Developmental Disabilities, Vocational Rehabilitation, Independent Living, Foster Care, Family Services, and Families Helping Families (FHF). Three survey instruments (Physician Survey, Agency Survey and Family Survey) were used to gather data from the corresponding stakeholder group. Each instrument involved collaborative stakeholder development and review.

Based on survey findings, a long range plan was developed to address needed improvements in care management and collaboration among agencies and among families and service providers. The long range plan includes enhanced coordination with FHF and Family to Family Health Information Centers (F2FHICs) in regional CSHS clinics and statewide to provide families self-advocacy information. In addition, FHF will facilitate information workshops to front-line stakeholder staff to increase knowledge of available services and referral between Department of Health and Hospitals (DHH) and Department of Social Services (DSS) agencies. This activity is consistent with the DSS-DHH Data Integration Project, a current collaboration between the two agencies to create a master patient index to facilitate a single point of entry for multiple program eligibility and care coordination. CSHS volunteered to help pilot this project. CSHS will continue to increase Medical Home capacity by establishing incentive contracts with primary care teaching practices to conduct care coordination and by providing technical assistance with care coordination to providers who expressed interest as a result of the Physician Survey. CSHS and Louisiana Birth Defects Monitoring Network (LBDMN) will coordinate with primary care practices, Louisiana Federally Qualified Health Centers (LFQHCs) and School Based Health Centers (SBHCs) to send Regional Resource Guides and Family Resource Guides to facilitate referral to community-based resources among providers and increase knowledge of available resources among families, respectively. CSHS will enhance its coordination with AAP and the Louisiana Academy of Family Physicians (LAFP) to advocate for the needs of CYSHCN in health care reform, through its collaboration with Medicaid to increase care coordination reimbursement, and by submitting articles on community-based resources and transition for inclusion in each academy's newsletter.

CSHS has maintained a long-standing partnership with many local and statewide public and private agencies and organizations to address the medical and community resource needs of Louisiana's CYSHCN. CSHS coordinates with Children's Hospital through its model program for specialized care of children with diabetes. CSHS assures a multi-disciplinary team of a pediatric diabetologist, pediatric diabetes nurse educator, pediatric nutritionist, pediatric psychologist, exercise trainer and visiting pediatric diabetes liaison nurse. The goal of the program is to reduce emergency room visits, improve growth and development of children, as well as decrease the average blood glucose level of the enrolled children. CSHS coordinates with Tulane University Hospital for Children to provide pediatric subspecialty medical treatment for CSHS eligible children who have or who are suspected of having Cystic Fibrosis. This program involves both inpatient and outpatient care and prescription coverage for CSHS eligible children. CSHS coordinates with Louisiana State University Health Sciences Center (LSUHSC) at Earl K. Long Medical Center in Baton Rouge as well as LSUHSC Shreveport to provide in-hospital and discharge planning for infants who receive Neonatal Intensive Care following birth, as well as follow-up in High Risk Clinics after discharge. CSHS coordinates with Southeast Louisiana Area

Health Education Center for a Statewide Parent Consultant who coordinates all aspects of family support and input into the CSHS program. CSHS contracts with FHF to provide parent liaisons in each of its nine regional subspecialty clinics to link families with community resources. CSHS provides subspecialty care for CYSHCN and their families in its regional clinics through partnerships with LSUHSC, Tulane University Medical Center, Ochsner Hospital and Children's Hospital. CSHS regional subspecialty clinics coordinate with local agencies, including schools, hospitals, FHF, parent support groups, Office of Mental Health, Office for Citizens with Developmental Disabilities, and private sub-specialists. In partnership with both LSU and Tulane Schools of Medicine, CSHS ensures that all pediatric residents trained in Louisiana understand the Medical Home model of care for CYSHCN, thereby provide comprehensive, family-centered, and coordinated care. Recently, CSHS has expanded this partnership to the LSU Family Practice residency program as well.

CSHS advocates for CYSHCN through representation on statewide councils and boards. The CSHS Director participates in the State Planning Council for Developmental Disabilities in Louisiana. Other members of this council include the Advocacy Center, LSUHSC Center for Excellence in Developmental Disabilities, self advocates, parents, State DOE, Office of Mental Health, Office for Citizens with Developmental Disabilities, Louisiana Rehabilitation Services, Governor's Office on Disability Affairs, Governor's Office on Elderly Affairs, and others. This ongoing collaboration addresses issues related to all aspects of life for persons with disabilities. The CSHS Director and the Statewide Care Coordinator Supervisor are members of the Advisory Board of the Louisiana Healthcare Quality Forum (LHCQF) Medical Home Committee. The LHCQF has been legislatively mandated to implement the Medical Home in Louisiana.

CSHS provides a continuum of services beginning at birth with birth defects surveillance and screening for disabilities. CSHS is implementing the LBDMN. The LBDMN Advisory Board consists of nine members including representatives from the Louisiana State Medical Society, Ochsner Foundation Medical Center, Tulane University Medical Center, LSUHSC, March of Dimes, MCH Coalition, Louisiana Office of Public Health, a parent representative, and a consumer representative. LBDMN partners with Lake Charles Memorial Hospital and Louisiana Public Health Institute for surveillance staff, and Spina Bifida Association of Greater New Orleans for its advisory board. LBDMN works closely with MCH for systems development.

The HSV Program within CSHS works closely with all birthing hospitals in the state to ensure hearing screening for all newborns. CSHS also coordinates with private audiologists and the medical community for follow-up evaluations as well as to provide needed services for families who lack insurance or have no access to local community services. CSHS coordinates with the Parent Pupil Education Program and Early Steps to ensure identified infants receive early intervention by 6 months. The State Advisory Council for Newborn Hearing Screening is appointed by the Governor, and includes 14 stakeholders that advise the program on the Early Hearing Detection and Intervention (EDHI) system in the state. EHDI works with Louisiana chapters of the Association of the Deaf, Commission for the Deaf, Hospital Association, AAP, LAFP, Speech/Language Hearing Association, American Speech/Language Hearing Association, American Academy of Audiology, Speech Language Pathologists and Audiologists in Louisiana Schools, and Board of Examiners for Speech Language Pathology and Audiology. EHDI partners with Southeast Louisiana Area Health Education Center for its nine statewide regional taskforce leaders and a statewide parent consultant.

F. Health Systems Capacity Indicators

Introduction

Health Systems Capacity Indicators are used as a monitoring/assessment tool. They are used to measure the state's effectiveness in maintaining or improving the overall health of the state's population of pregnant women, women of child bearing age, infants, children and children with special health care needs. State MCH efforts have been successful in improving early and adequate prenatal care. Examination of the data for disparities is vital in order to tailor efforts to

reach out to populations and areas in greatest need, in order to make further progress. There are concerns post-Hurricanes about the capacity of the state's health service infrastructure to provide adequate services and the HSCI enables such monitoring.

The goal of the State System Development Initiative (SSDI) grant is to enhance the data capacity of Louisiana's Maternal and Child Health (MCH) and Children with Special Health Care Needs (CSHCN) Programs. Improving existing and establishing new data linkages and surveillance systems enhance data capacity. Current linkages between the birth files, infant death files, Medicaid eligibility files, women, infant, and child program (WIC) eligibility files, and newborn screening data will continue to allow in depth analyses by MCH and CSHCN Programs, which identify priority needs for programs and interventions. Data is used as an indicator for developing new strategies and efforts to address emerging population needs.

Health Systems Capacity Indicator 01: *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	60.3	57.1	55.3	55.3	55.3
Numerator	1817	1722	1650	1650	1650
Denominator	301375	301375	298157	298157	298157
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
Data is preliminary and based upon the 2008 data.

Notes - 2008
Data is preliminary and based upon 2007 data.

Notes - 2007
Data is final and is based upon 2007 Louisiana Hospital Inpatient Discharge Data (LAHIDD). Since 2002, the primary data source of analysis and reporting for this indicator is the Louisiana Hospital Inpatient Discharge Data (LAHIDD). LAHIDD is compiled by the Health Statistics Department of the Louisiana Office of Public Health, and Injury Research and Prevention Program analyzes the data needed for this indicator. Since participation in reporting hospital inpatient discharge data is not mandatory in Louisiana, then differences in the number, size, and type of hospitals reporting annually will affect our data reported. The variability limits year-to-year comparison analyses.

Narrative:
Final data shows a decrease in the rate of children hospitalized for asthma in 2007 at 55.3 per 10,000 children under 5 years of age compared to 57.1 per 10,000 in 2006 and 60.3 per 10,000 in 2005. Compared to the 2004 rate of 74.4 per 10,000, the 2007 asthma hospitalization rate of children <5 years of age has decreased by 25.6%.

Factors influencing this indicator include access to data to identify risks and asthma triggers,

quality disease prevention, and health/asthma education, access to and utilization of appropriate medical care and medication, and relevant health care policy and practice issues

The Louisiana Bureau of Primary Care's Asthma Control Program developed one of the state's first surveillance systems to focus on children with asthma. Surveillance data analysis of childhood asthma indicators can measure asthma prevalence among children < 18 years. Louisiana childhood asthma data sources include: Louisiana Vital Statistics, Louisiana Medicaid paid claims, Louisiana Hospital Inpatient Discharge Data, emergency room data, Behavioral Risk Factor Surveillance System- Optional Childhood Asthma Module, Office of Public Health's Environmental Epidemiology and Toxicology Section, Louisiana Department of Environmental Quality ozone and particulate data, and Edgear school asthma data.

Enrollment of eligible children into Louisiana Medicaid/LaCHIP/ LACHIP Affordable Program for families with income between 200-250 percent of FPL will increase access to medical homes, preventive medical management, and to Medicaid's asthma support services. Louisiana CommunityCARE's "Achieving Better Care for Asthma" is a statewide project available to Medicaid recipients to promote healthy behaviors; to improve medical home management by providing education, office management tools, and utilization data to providers; and to develop patient self-care through education. "Asthma HELP" Program is a free telephone-based pharmacy care program that provides printed education materials, asthma action plans, guideline summaries, and monthly telephone counseling to Louisiana Medicaid recipients from licensed Louisiana pharmacists certified by the National Asthma Educators Certification Board as asthma educators.

The Louisiana Childhood Asthma Surveillance Collaborative (LASC), within the Chronic Disease Prevention and Control Section with the Department of Health and Hospitals, provides guidance and assists DHH in assessing, evaluating, and determining correlations with current state asthma data to improve community collaborations, advocate for an asthma-friendly environments, and develop a comprehensive asthma education program for schools, providers, and other members of the community. LASC received a grant to fund regional coordinators to provide community education and outreach statewide to establish asthma friendly communities, including schools and child care centers.

Health Systems Capacity Indicator 02: *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	87.5	89.8	90.2	89.9	90.8
Numerator	40441	40505	43931	43757	43871
Denominator	46225	45119	48707	48699	48328
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009

From Louisiana Medicaid Management Information Systems, HCFA 416, for dates of service 10/01/2008 - 09/30/2009. Since Louisiana's SCHIP program is through Medicaid expansion, the numerator and denominator Include children enrolled in LaCHIP.

Notes - 2008
From Louisiana Medicaid Management Information Systems, HCFA 416, for dates of service 10/01/2007 - 09/30/2008. Since Louisiana's SCHIP program is through Medicaid expansion, the numerator and denominator Include children enrolled in LaCHIP.

Notes - 2007
From Louisiana Medicaid Management Information Systems, HCFA 416, for dates of service 10/01/2006 - 09/30/2007. Since Louisiana's SCHIP program is through Medicaid expansion, the numerator and denominator Include children enrolled in LaCHIP.

Narrative:
The percent Medicaid enrollees under age 1year who received at least one periodic screen increased to 90.8% in 2007, compared to 89.9% in 2008, 90.2% in 2007, 88.6% in 2006, and 87.5% in 2005.

This indicator reflects the capacity of Louisiana's healthcare system to provide services, which include provider enrollment; opportunities to access preventive healthcare services with a primary care physician; and patient utilization of accessible services.

Louisiana Covering Kids & Families Coalition Project is a state-funded, community-based Medicaid/LaCHIP outreach and education project that consists of 11 regional coalitions to provide families of eligible children enrollment assistance. Louisiana MaxEnroll Initiative, implemented in February 2009, is a four-year enrollment project funded by the new Robert Wood Johnson Foundation's Maximizing Enrollment grant. The goal is to enroll 98% of eligible children in Medicaid or LaCHIP by year 2013. Also, income eligibility for state-sponsored health insurance programs is checked for pregnant women, infants, and children accessing services in the Office of Public Health (OPH) Public Health Units (for WIC or other health services), School-based Health Centers (SBHC), Federally Qualified Health Centers (FQHC), Rural Health Centers, and/ a Sabine Parish Neighborhood Place, which is an integrated service delivery system that provides a one-stop shop for state services in Many and Zwolle, Louisiana.

Louisiana Medicaid/LaCHIP recipients are enrolled in the Department of Health and Hospitals' (DHH) CommunityCARE Program, which is a comprehensive health delivery system that links recipients to a primary care physician, creating a "medical home". The participating physicians provide enrolled children with preventive care, including periodic EPSDT preventive health screens, outpatient and hospital inpatient care, health education, and referrals to specialists.

The MCH Program will continue to support delivery of preventive health services, such as health screenings, immunizations, and parental education, to low income infants and children in the state's public health clinics, school base health centers, and contract clinics; screen infant and children seen in the public health clinics for Medicaid eligibility; provide technical assistance to the Medicaid program on issues related to access to services for children; and support the medical home efforts, including dental medical homes, of the state, including CSHS, Adolescent School-based Health Initiative, BrightStart Advisory Council (Louisiana's MCHB-Early Childhood Comprehensive Systems Initiative), Oral Health Program, and the Louisiana Chapter of the American Academy of Pediatrics.

Health Systems Capacity Indicator 03: *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009

Annual Indicator	86.4	53.6	89.3	91.3	90.2
Numerator	459	260	509	496	450
Denominator	531	485	570	543	499
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
Data is provided by the Medicaid Office.

Notes - 2008
Data is provided by the Medicaid Office.

Notes - 2007
Data is provided by the Medicaid Office.

Narrative:
The percentage of LaCHIP enrollees under age one year who received at least one periodic screen in 2009 was 90.2%, which is slightly lower than the rate of 91.3% in 2008 but higher than 89.2% in 2007, 53.6% in 2006, and 86.4% in both 2005 and 2004.

This indicator reflects the capacity of Louisiana's healthcare system to provide services, which include provider enrollment; opportunities to access preventive healthcare services with a primary care physician; and patient utilization of accessible services.

Louisiana Covering Kids & Families Coalition Project is a state-funded, community-based Medicaid/LaCHIP outreach and education project that consists of 11 regional coalitions to provide families of eligible children enrollment assistance. Louisiana MaxEnroll Initiative, implemented in February 2009, is a four-year enrollment project funded by the new Robert Wood Johnson Foundation's Maximizing Enrollment grant. The goal is to enroll 98% of eligible children in Medicaid or LaCHIP by year 2013. Also, income eligibility for state-sponsored health insurance programs is checked for pregnant women, infants, and children accessing services in the Office of Public Health (OPH) Public Health Units (for WIC or other health services), School-based Health Centers (SBHC), Federally Qualified Health Centers (FQHC), Rural Health Centers, and Sabine Parish Neighborhood Place, which is an integrated service delivery system that provides a one-stop shop for state services in Many and Zwolle, Louisiana.

Louisiana Medicaid/LaCHIP recipients in Louisiana are enrolled in the Department of Health and Hospitals' (DHH) CommunityCARE Program, which is a comprehensive health delivery system that links recipients to a primary care physician, creating a "medical home". The participating physicians provide enrolled children with preventive care, including periodic EPSDT preventive health screens, outpatient and hospital inpatient care, health education, and referrals to specialists.

The MCH Program will continue to support delivery of preventive health services, such as health screenings, immunizations, and parental education, to low income infants and children in the state's public health clinics, school base health centers, and contract clinics; screen infant and children seen in the public health clinics for Medicaid eligibility; provide technical assistance to the Medicaid program on issues related to access to services for children; and support the medical home efforts, including dental medical homes, of the state, including CSHS, Adolescent School-based Health Initiative, BrightStart Advisory Council (LA.'s MCHB-Early Childhood Comprehensive Systems Initiative), Oral Health Program, and the Louisiana Chapter of the American Academy of Pediatrics.

Health Systems Capacity Indicator 04: *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	89.7	90.0	90.0	90.2	90.2
Numerator	53901	56593	59172	58371	58371
Denominator	60109	62870	65744	64737	64737
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008
2008 data is preliminary Louisiana vital statistics data.

Narrative:
Final 2007 data for this indicator was 90.1%, preliminary 2008 data is 90.2%. Prenatal care access and utilization serve several important roles in monitoring the maternity population as an indicator of overall prenatal services including availability, provider willingness to accept Medicaid, transportation to care issues, patient utilization of services and awareness of benefits of care. Prenatal care rates in Louisiana are improving, and infant mortality rates remain high but have decreased from 10.4 in 2004, 10.1 in 2005, 10.0 in 2006 to 9.0 in 2007 and preliminary data of 9.2 in 2008. In 2008, 68.4% of births were covered by Medicaid. MCH works with Medicaid for early entry into prenatal care by housing Medicaid eligibility staff in the public health unit system. Medicaid has expedited the application process and women are enrolled quickly. MCH has contracts to provide prenatal care in areas where private providers are not available. A number of providers in the New Orleans region employ bi-lingual Spanish speaking staff. The Partners for Healthy Babies media campaign targets prenatal care as one of its primary messages, promoting early access to prenatal care. MCH provides free pregnancy testing in all Office for Addictive Disorders clinics statewide, with 2093 pregnancy tests given last year. Of these 35 women had positive pregnancy tests and were referred to a prenatal provider.

Data sharing agreements are ongoing with Louisiana vital records, Medicaid, Hospital Inpatient Discharge Data (LaHIDD), and Pregnancy Risk Assessment Monitoring System (LaPRAMS). Access has also been granted to data from the Louisiana Birth Defects surveillance program conducted by CSHCN and Caring Community Youth Survey conducted by the Office for Addictive Disorders. These additional data sources expand capacity to increase data analysis and dissemination of information. A primary goal of the State Systems Development Initiative (SSDI) is to enhance the data capacity of Louisiana's Maternal and Child Health (MCH) and Children with Special Health Care Needs (CSHCN) Programs. Improving existing and establishing new data linkages and surveillance systems enhance data capacity. Linkages between the birth files, infant death files, Medicaid eligibility files, women, infant, and child program (WIC) eligibility files, and newborn screening data continue to allow in-depth analyses by MCH and CSHCN Programs, which identify priority needs for programs and interventions. Data on prenatal visits are collected and analyzed through vital records and LaPRAMS. Although LaPRAMS operations ceased following the 2005 hurricanes, LaPRAMS resumed data collection in mid-2006 and completed a

full year in 2007.

Health Systems Capacity Indicator 07A: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	92.3	83.2	85.5	89.9	92.9
Numerator	666584	636648	645924	663982	698453
Denominator	721919	764825	755539	738184	751603
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009

NOTE: For 2005-2008, data was obtained from the Louisiana Medicaid Program. The numerator is the (unduplicated) number of Medicaid recipient children under age 19 years who received a medical service during the respective FFY, by date of service, in which CommunityCARE administrative fees are not considered paid claims. The denominator is the number of children enrolled in Louisiana CommunityCare (Medicaid/LaCHIP), eligible for services. Retroactive eligibility is included in reporting these figures.

Notes - 2008

For 2008, data was obtained from the Louisiana Department of Health and Hospitals Medicaid Annual Reports for Federal Fiscal Year 2007/2008. The numerator is the (unduplicated) number of all Medicaid children (Title XIX and XXI) under age 19 years who received at least one processed claim during the period involved, whether or not he/she was enrolled on the date the claim was paid but was enrolled at the time the service for the claim was provided. The denominator is the number of all children who applied and have been approved to receive services, regardless of whether he/she received services and/or any claims have been filed on his/her behalf. Therefore, any post-annual report data of all Medicaid children's enrollment, recipients of service(s), and/or total costs of received services received for a specific state fiscal year, which is obtained after the date of the data used for the Medicaid report, will differ from the data in the report because retroactive eligibility will be included in the new figures.

Notes - 2007

For 2006 and 2007, data was obtained from the Louisiana Department of Health and Hospitals Medicaid Annual Reports for State Fiscal Year 2005/2006 and 2006/2007. The numerator is the (unduplicated) number of all Medicaid children (Title XIX and XXI) under age 19 years who received at least one processed claim during the period involved, whether or not he/she was enrolled on the date the claim was paid but was enrolled at the time the service for the claim was provided. The denominator is the number of all children who applied and have been approved to receive services, regardless of whether he/she received services and/or any claims have been filed on his/her behalf. Therefore, any post-annual report data of all Medicaid children's enrollment, recipients of service(s), and/or total costs of received services received for a specific state fiscal year, which is obtained after the date of the data used for the Medicaid report, will differ from the data in the report because retroactive eligibility will be included in the new figures.

Narrative:
The percentages of potentially Medicaid-eligible children who received a paid service by Medicaid increased to 92.9% in 2009 from 89.9% in 2008, 85.5% in 2007, 83.2% in 2006 and 92.3% in 2005. Also, in 2009, slightly more children received a paid service than in 2005 (Pre-Hurricanes Katrina/Rita).

This indicator reflects the following: enrollment of eligibles; Louisiana's healthcare system's capacity to provide services, including healthcare provider enrollment and retention; accessibility to preventive healthcare services with a primary care physician; and patient utilization of accessible services.

Louisiana Covering Kids & Families Coalition Project is a state-funded, community-based Medicaid/LaCHIP outreach and education project that consists of 11 regional coalitions to provide families of eligible children enrollment assistance. Louisiana MaxEnroll Initiative, implemented in February 2009, is a four-year enrollment project funded by the new Robert Wood Johnson Foundation's Maximizing Enrollment grant. The goal is to enroll 98% of eligible children in Medicaid or LaCHIP by year 2013. Also, income eligibility for state-sponsored health insurance programs is checked for pregnant women, infants, and children accessing services in the Office of Public Health (OPH) Public Health Units (for WIC or other health services), School-based Health Centers (SBHC), Federally Qualified Health Centers (FQHC), Rural Health Centers, and/or a Sabine Parish Neighborhood Place, which is an integrated service delivery system that provides a one-stop shop for state services.

Louisiana Medicaid/LaCHIP recipients are enrolled in the CommunityCARE Program, a comprehensive health delivery system that links recipients to a primary care physician, creating a "medical home". Participating physicians provide enrolled children with preventive care, including periodic EPSDT preventive health screens, outpatient and hospital inpatient care, health education, and referrals to specialists. CommunityCare's Immunization Pay-for-Performance Initiative provides incentive bonus payments to participating Louisiana Medicaid Primary Care Case Management (PCCM) enrolled providers to increase the number of 24-month-old Medicaid/CHIP-eligible children who are up-to-date with childhood vaccines.

MCH supports the delivery of preventive health services, such as health screenings, immunizations, and parental education, to children in the state's public health clinics, school base health centers, and contract clinics; screen infant and children seen in the public health clinics for Medicaid eligibility; provide technical assistance to the Medicaid program on issues related to access to services for children; and support the medical home efforts, including dental medical homes, of the state, including CSHS, Adolescent School Health Initiative, BrightStart Advisory Council (Louisiana's MCHB-ECCS Grant Initiative), Oral Health Program, and the Louisiana Chapter of the American Academy of Pediatrics.

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	42.0	40.2	40.4	44.5	51.9
Numerator	62777	58224	62241	66807	80319
Denominator	149564	144751	153948	150115	154801
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3					

years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
From Louisiana Medicaid Management Information Systems, HCFA 416, for dates of service 10/01/2008 - 09/30/2009.

Notes - 2008
From Louisiana Medicaid Management Information Systems, HCFA 416, for dates of service 10/01/2007 - 09/30/2008.

Notes - 2007
From Louisiana Medicaid Management Information Systems, HCFA 416, for dates of service 10/01/2006 - 09/30/2007.

Narrative:
According to the Louisiana Medicaid Management System, in the federal fiscal year (FFY) 2008-2009, there were 154,801 children ages 6 to 9 years, enrolled in Medicaid, and only 80,315 received any dental services. This accounts for 52% of the enrolled children. From FFY 2006 to 2009, the percentage of Medicaid enrolled children ages 6 to 9 years who received any dental services increased from 37.4% to 52%. Medicaid reimbursement rates and allowed services have increased over the last few years; however the state has seen only small gains in the number of dentist billing Medicaid for reimbursement.

Access to oral health care is a problem. Louisiana suffers from a shortage of dentists, especially in rural areas. In Louisiana in 2009, 56 out of 64 parishes (87.5% of the state) were designated as Dental Health Professional Shortage Areas, having on average, 40% fewer dentists and 42% fewer dental hygienists than other states. Compounding the problem, only 26% of licensed dentists participated in the Medicaid program and only 16% billed Medicaid for $10,000 or more. On average in Louisiana, among Medicaid- eligible children, one dentist is available for 1,161 children. According to the dental screening survey 33.2% of the Louisiana's 3rd grade children had protective dental sealants on at least one of their permanent molar teeth, 41.9% had untreated dental caries, 65.7% had dental caries experience, and 42.7% had to be referred to dentists for treatment.

The Oral Health Program coordinates a school-based dental sealant program, for 2nd and 6th grade students in schools where over 50% of students are eligible for a free or reduced lunch. The school-based sealant program conducts preliminary dental screenings by a dentist and then applies sealants on appropriate teeth. This initiative has received HRSA funding from 2006-2009 and then renewed from 2009-2012 to provide professional services, supplies and equipment. While this initiative has resulted in services to only 9% of targeted schools in the state, the capacity is there for continued expansion. The school-based sealant program is continuing to work on sustainability of this initiative through securing Medicaid reimbursement for the placement of a dental sealant. Funds realized from Medicaid reimbursement would then be utilized to contract for services, maintain portable dental equipment and initiate active referral services for children with need.

In the 2008-2009 school year, the Oral Health Program expanded the school-based dental sealant program from ten parishes to twelve parishes. Parishes participating in the program included Allen, Avoyelles, Caddo, Catahoula, Concordia, East Baton Rouge, East Feliciana, Lafayette, LaSalle, Madison, Rapides and Orleans. The number of schools participating increased from 45 to 57. The number of children screened increased from 2,676 to 2,852 with the number of sealants place increased from 4,967 to 6,302.

Health Systems Capacity Indicator 08: *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	8.4	5.6	4.3	3.7	3.4
Numerator	2058	1400	1101	1055	992
Denominator	24448	25036	25541	28385	29540
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
Source for 2009 numerator is Medicaid. The Denominator is from the Social Security Administration, Supplemental Security Record (Characteristic Extract Record format), 100 percent data. Table: "Number of children under age 16 receiving federally administered SSI payments, by state or other area, December 2009."

Notes - 2008
Source for 2008 numerator is Medicaid. The Denominator is from the Social Security Administration, Supplemental Security Record (Characteristic Extract Record format), 100 percent data. Table: "Number of children under age 16 receiving federally administered SSI payments, by state or other area, December 2008."

Notes - 2007
Source for 2007 numerator is Medicaid. The Denominator is from the Social Security Administration, Supplemental Security Record (Characteristic Extract Record format), 100 percent data. Table: "Number of children under age 16 receiving federally administered SSI payments, by state or other area, December 2007."

Narrative:
CSHS provides direct care in sub-specialty clinics in each region of the state for CSHCN without access to care. Because the eligibility of the program is restricted financially and medically, not all children with SSI qualify for CSHS. In addition, because children with SSI have Medicaid, many of them are able to access care in the private sector. When the needed sub-specialist is not available, either because of provider shortages in the region or because providers that are available do not take Medicaid, CSHS provides the care.

The reporting of this indicator is also influenced by data collection. Data available to CSHS from the Medicaid program does not differentiate between CSHCN receiving Title II (including dependents of disabled individuals) and Title XVI (for disabled individuals) services, although most children receive Title XVI services. The estimate is therefore deflated.

Regional CSHS offices currently have working relationships with their Medicaid and SSI offices. Children attending CSHS clinics who are eligible for SSI benefits are referred to the SSI office. Attempts to receive SSI data directly from the SSI office in order to contact families who may be interested in CSHS services have not been successful because the data sharing agreement with the federal office does not include access by other agencies. CSHS has made repeated attempts to have this data sent to CSHS on a regular basis from Medicaid, which is the program within

DHH that receives SSI recipient data, but to date has not been successful.

Limited eligibility as well as inflation of the number of children with SSI disability will remain factors in preventing improvement of this indicator.

Health Systems Capacity Indicator 05A: *Percent of low birth weight (< 2,500 grams)*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of low birth weight (< 2,500 grams)	2008	matching data files	12.6	7.9	11.2

Narrative:
Medicaid serves to increase access and provide care for otherwise unfunded citizens and implies that the Medicaid population may have higher risks, such as increased poverty, poorer access to care, less education opportunities, compared to the non-Medicaid population. Reflective of these increased risks, the low birth weight (LBW) rate for the Medicaid population is significantly higher than the non-Medicaid population. Preliminary 2008 low birth weight rate was 12.6% vs. 7.9% respectively. The overall preliminary low birth weight rate for 2008 was 11.2% as compared to 11.3% for 2007.

LBW can provide valuable information as a general indicator of the state's maternal health status and prenatal care provision. While a surrogate marker for prematurity, it can also identify infants who have intrauterine growth restriction. By analyzing LBW infants, by regions and specific population groups such as payer type, it can help direct resources to those areas in most need. Specific interventions include the IMRI, smoking cessation program, dental services program, substance abuse and depression screening programs and prenatal services in areas with increased infant mortality and prematurity rates. Data linkages are in place with Louisiana Hospital Inpatient Discharge Data (La HIDD) and with the Louisiana Pregnancy Risk Assessment Monitoring System (PRAMS). Efforts are established to access to the Louisiana Birth Defects Survey conducted by CSHCN and Caring Community Youth Survey conducted by the Office for Addictive Disorders, and increase data analysis and dissemination of information from PRAMS and its linked data. The SBIRT program screening for alcohol use, tobacco use, substance abuse, depression and domestic violence in pregnancy is actively screening in public and private prenatal clinics in 8 of 9 regions of the state. Medicaid will require screening all pregnant women for tobacco use, a risk for preterm birth in October 2010. MCH collaborations with the DHH Tobacco Control Program and additional staff in MCH will focus this effort in training private providers. Take Charge and Family Planning are providing increased access to services for Medicaid eligible women, including tobacco cessation counseling. MCH provides Folic Acid to all women in OPH Family Planning clinics and is now providing multi-vitamins with folic acid. An expanded focus on preconceptional/interconceptional health services is occurring, especially in regard to prevention of adverse pregnancy outcomes. State System Development Initiative (SSDI) grant enhances the data capacity of MCH and Children with Special Health Care Needs (CSHCN) Programs. Current linkages between the birth files, infant death files, Medicaid eligibility files, women, infant, and child program (WIC) eligibility files, and newborn screening data continues.

Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births*

INDICATOR #05 *Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State*	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Infant deaths per 1,000 live births	2008	matching data files	10.6	5.6	9.1

Narrative:
The 2008 preliminary infant death rate of the Medicaid population was 10.6 per 1,000 compared to 5.6 per 1,000 for the non-Medicaid population. Both rates reveal a decline from 2005 rates of 11.9 and 6.6 per 1,000, respectively. The infant death rate for all groups remained steady at 9.1 in 2008 as compared to 9.0 in 2007.

Medicaid provides access and care for otherwise unfunded citizens, implying that the Medicaid population may have higher risks, such as increased poverty, poor access to care, less education opportunities, and higher utilization of substances as compared to the non-Medicaid population who would be assumed to have commercial insurance. By comparison of the 2 groups, indicators of areas to target for intervention result. Infant mortality serves as a broad marker of health status and health care utilization for women and children. Many factors contribute to infant mortality, but preterm births, especially those less than 1500 grams, contribute heavily to the measure and is recognized and utilized by the general public and provides valuable comparison of a state over time, and by trending, can serve as a marker for intervention success. It is important in evaluation of specific groups, as in the disparity present in African American and white births. Comparison between regions, states, and other countries of this marker are common. Multiple interventions have begun, including FIMR in each region, collaboration with other state agencies (Office of Minority Health Access, Medicaid, Mental Health, Tobacco Control, Addictive Disorders), SIDS/SUID media and education on the local level, and smoking/addictive disorder screening and treatment, faith based groups. Regional FIMR groups have placed increased focus and interventions on infant mortality, preterm births, and racial disparities. The Family Planning waiver, Take Charge, provides increased access to services for Medicaid eligible women. The State System Development Initiative (SSDI) grant enhances data capacity of Louisiana's Maternal and Child Health (MCH) and Children with Special Health Care Needs (CSHCN) Programs. Improving existing and establishing new data linkages and surveillance systems will enhance data capacity. Current linkages between the birth files, infant death files, Medicaid eligibility files, women, infant, and child program (WIC) eligibility files, and newborn screening data continues to allow in depth analyses by MCH and CSHCN Programs, which identify priority needs for programs and interventions. Data linkages are developed with Louisiana Hospital Inpatient Discharge Data (La HIDD) and with the Louisiana Pregnancy Risk Assessment Monitoring System (PRAMS). Efforts are established to access Louisiana Birth Defects Survey conducted by CSHCN and Caring Community Youth Survey conducted by the Office for Addictive Disorders, and increase data analysis and dissemination of information from PRAMS and its linked data.

Health Systems Capacity Indicator 05C: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05 *Comparison of health system capacity indicators for Medicaid,*	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL

non-Medicaid, and all MCH populations in the State					
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2008	matching data files	82.5	96.6	86.8

Narrative:
Preliminary 2008 data indicates percent of infant born to women receiving prenatal care in the first trimester is 86.8% and the Medicaid population rate was 82.5% compared to 96.6% among the non-Medicaid Population.

MCH program funds direct prenatal services to indigent pregnant women in areas where there are access to care problems. The statewide MCH Partners for Healthy Babies (PHB) campaign promotes early prenatal care through all of its activities, including multimedia, public relations and other communication strategies. The Partners for Healthy Babies website is continuously being updated to reflect needs of both providers and parents.

Fetal & Infant Mortality Review Initiatives (FIMR) have been established in all regions of the state. The FIMR program (staff and coalition structure) is charged with assessing service delivery gaps including prenatal care. Partners for Healthy Babies supports public relations efforts of Fetal & Infant Mortality Review coordinators to engage local media to highlight relevant issues. The Nurse Family Partnership (NFP), nurse home visiting program provides case management services for first time mothers statewide, assuring early and adequate care for its enrollees. FIMR programs collaborate with Healthy Start programs in 5 of 9 DHH regions and encourage providers to refer to Healthy Start and/or NFP.

The Fetal and Infant Mortality Reduction (FIMR) programs, through the Community Action Teams, serve as umbrella organizations within the community for MCH issues. FIMRs provided regional Needs Assessment meetings. Parishes in the lowest quartile for first trimester entry into prenatal care are targeted by Regional IMRI Community Action Teams for the development of additional prenatal initiatives. OPH partnered with the March of Dimes to implement regional CenteringPregnancy Programs, one of which targets Latina clients; others are in areas where there is inadequate access to prenatal care. State MCH efforts have been successful in improving early and adequate prenatal care. However, in order to address unchanging disparities in infant mortality and low birth weight, programs will be specifically tailored to reach out to populations and areas in greatest need.

Health Systems Capacity Indicator 05D: *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of pregnant women with adequate prenatal care(observed to	2008	matching data files	89.2	92.4	90.2

expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])					

Narrative:
Preliminary 2008 data indicate that the rate was 90.2% and for the Medicaid population was 89.2% compared to 92.4% for the non-Medicaid population.

MCH program funds direct prenatal services to indigent pregnant women in areas where there are access to care problems. To assure adequate prenatal care in the Medicaid population, the MCH program collaborates with 4 Healthy Start programs covering 5 regions of the state. The statewide MCH Partners for Healthy Babies (PHB) campaign promotes early prenatal care through all of its activities, including multimedia , public relations and other communication strategies.PHB messages are designed to resonate with target audiences that have limited access to resources, including the Medicaid population. Fetal & Infant Mortality Review Initiatives (FIMR) are in all regions of the state. Regional FIMRs conducted Needs Assessment meetings. The FIMR program (staff and coalition structure) is charged with assessing service delivery gaps including prenatal care. The Nurse Family Partnership, nurse home visiting program provides case management services for first time Medicaid eligible mothers statewide, assuring early and adequate care for its enrollees.

State MCH efforts have been successful in improving early and adequate prenatal care. In order to address disparities, programs are being tailored to reach out to populations and areas in greatest need, in order to make further progress.

Health Systems Capacity Indicator 06A: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Infants (0 to 1)	2009	200
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Infants (0 to 1)	2009	200

Notes - 2011
Since April of 2008, families with incomes between 200 and 250 percent of FPL will be able to obtain health coverage at an affordable monthly premium and with co-payments through the new LaCHIP Affordable Plan.
For all children ages 0 through 19 years, the percent of poverty level for eligibility in Louisiana Medicaid and LaCHIP is up to 200% at no cost.

Narrative:
The percent of poverty level for eligibility of infants (0 to 1 year) in the State's Medicaid Program and LaCHIP Program remains at up to 200% of FPL. Eligibility for LaCHIP Affordable Plan is a family with income between 200-250 percent of FPL. Each year the U.S. Department of Health and Human Services adjusts the federal poverty guidelines to determine financial eligibility for certain programs such as no-cost or low-cost health insurance. The current monthly income eligibility threshold for a family of four is $3,675 for LaCHIP and $4,594 for the LaCHIP Affordable Plan. However, health insurance alone cannot reduce the inequities in healthcare access. Therefore, beyond expanding health insurance coverage for children, further efforts are also

needed to increase patient utilization of services and healthcare provider participation in the Medicaid Program.

Poverty levels can be a broad measure of the health status and welfare of infants and children. Eligibility rules help the state and MCH Program assess needs of children based on the estimated number of children eligible to participate in Medicaid and LaCHIP programs but who remain uninsured.

The MCH Program will continue to support activities to mitigate the adverse affects of poverty on an infant and child's physical, cognitive, emotional, and behavioral development by driving policy making efforts at the state level, especially through active involvement in healthcare reform to meet the priority needs of low-income MCH populations, BrightStart Advisory Council (Louisiana's MCHB-ECCS Initiative and the Governor-appointed Early Childhood Advisory Council), Governor's Children's Cabinet Advisory Board and by supporting the delivery of health and social services in public health units, Federally Qualified Health Centers, Rural Health Centers, and in private provider clinic settings.

Health Systems Capacity Indicator 06B: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Medicaid Children (Age range 1 to 5) (Age range 6 to 14) (Age range to)	2009	 200 200
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Medicaid Children (Age range 1 to 19) (Age range to) (Age range to)	2009	 200

Notes - 2011
Since April of 2008, families with incomes between 200 and 250 percent of FPL will be able to obtain health coverage at an affordable monthly premium and with co-payments through the new LaCHIP Affordable Plan.
For all children ages 0 through 19 years, the percent of poverty level for eligibility in Louisiana Medicaid and LaCHIP is up to 200% at no cost.

Notes - 2011
Since April of 2008, families with incomes between 200 and 250 percent of FPL will be able to obtain health coverage at an affordable monthly premium and with co-payments through the new LaCHIP Affordable Plan.
For all children ages 0 through 19 years, the percent of poverty level for eligibility in Louisiana Medicaid and LaCHIP is up to 200% at no cost.

Narrative:
The percent of poverty level for eligibility of children in the State's Medicaid Program and LaCHIP Program remains at up to 200% of FPL. Eligibility for LaCHIP Affordable Plan is a family with income between 200-250 percent of FPL. Each year the U.S. Department of Health and Human

Services adjusts the federal poverty guidelines to determine financial eligibility for certain programs such as no-cost or low-cost health insurance. The current monthly income eligibility threshold for a family of four is $3,675 for LaCHIP and $4,594 for the LaCHIP Affordable Plan. However, health insurance alone cannot reduce the inequities in healthcare access. Therefore, beyond expanding health insurance coverage for children, further efforts are also needed to increase patient utilization of services and healthcare provider participation in the Medicaid Program.

Poverty levels can be a broad measure of the health status and welfare of infants and children. Eligibility rules help the state and MCH Program assess needs of children based on the estimated number of children eligible to participate in Medicaid and LaCHIP programs but who remain uninsured.

The MCH Program will continue to support activities to mitigate the adverse affects of poverty on an infant and child's physical, cognitive, emotional, and behavioral development by driving policy making efforts at the state level, especially through active involvement in healthcare reform to meet the priority needs of low-income MCH populations, BrightStart Advisory Council (Louisiana's MCHB-ECCS Initiative and the Governor-appointed Early Childhood Advisory Council), Governor's Children's Cabinet Advisory Board and by supporting the delivery of health and social services in public health units, School-based Health Centers, Federally Qualified Health Centers, Rural Health Centers, and in private provider clinic settings.

Health Systems Capacity Indicator 06C: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Pregnant Women	2009	200
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Pregnant Women		

Notes - 2011

.

Notes - 2011

Pregnant women are covered under the state's LaMOMS program. This program is a standard Medicaid program and is not covered by SCHIP funds.

Narrative:

The Medicaid program for pregnant women was renamed LaMOMS in 2003 and expanded to include women with income up to 200% FPL. Prior to January 2003, only mandatory (up to 133% FPL) pregnant women were covered. LaMOMS program was expanded to increase access to prenatal care, to improve birth outcomes, and to ultimately reduce the state's infant mortality rate. Medicaid pays for pregnancy-related services, delivery, and care up to 60 days after the pregnancy ends, including doctor visits, lab work, lab tests, prescriptions, and hospital care. The ability to maintain and/or improve eligibility levels are influenced by the state budget.

Since May 1, 2007, the SCHIP (Title XXI) children's health insurance program expanded prenatal care coverage by providing coverage eligibility for non-citizen pregnant women who are not otherwise eligible for Medicaid. The coverage is for prenatal care for this population.

The Louisiana Medicaid Program provides applications online. Applications are available in Spanish and Vietnamese.

Expansion of family planning through the Family Planning Waiver Take Charge which targets post-partum and reproductive age women below 200 percent of the federal poverty level has been in place since 2007.

The data serves as a comparative tool to other states and the associated outcomes.

The Louisiana State Systems Development Initiative (SSDI) program focuses on obtaining linked data, surveys, and registries. MCH epidemiologists will conduct studies and evaluations that will provide relevant information to program staff and policy makers in order to develop interventions that will help the state to meet national and state performance targets. SSDI program analysis and results will be disseminated at the state and local levels in the form of: 1) presentations to the State Perinatal Commission, the MCH Coalition, and internal and external meetings and conferences (e.g., MCH Epidemiology conference), 2) publications, such as the Louisiana State Medical Society Journal, Baby Talk Newsletter, and The Louisiana Morbidity Report, and 3) data and information on the state intranet and internet sites.

Health Systems Capacity Indicator 09A: *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

DATABASES OR SURVEYS	**Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)**	**Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)**
ANNUAL DATA LINKAGES Annual linkage of infant birth and infant death certificates	3	Yes
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	3	Yes
Annual linkage of birth certificates and WIC eligibility files	3	Yes
Annual linkage of birth certificates and newborn screening files	3	Yes
REGISTRIES AND SURVEYS Hospital discharge survey for at least 90% of in-State discharges	3	Yes
Annual birth defects surveillance system	2	Yes
Survey of recent mothers at	3	Yes

least every two years (like PRAMS)		

Notes - 2011

Narrative:
The MCH Program employs its Epidemiology, Assessment and Evaluation (EAE) unit to provide relevant MCH data to monitor MCH health indicators, evaluate programs, and assist in Title V MCH Needs Assessments. The EAE unit includes a CDC assignee MCH epidemiology team leader, a SSDI coordinator/ senior MCH epidemiologist, a junior MCH epidemiologist, a Pregnancy Risk Assessment Monitoring System (PRAMS) coordinator, and a PRAMS operations assistant. In August 2010, a master's level CSTE fellow will join the EAE unit for two years. The Title V-MCH Director oversees the EAE unit. In addition, the CSHCN Director supervises one full-time epidemiologist who collaborates with EAE staff.

Louisiana has a State Systems Development Initiative (SSDI) in place to support HSCI 09A. The SSDI coordinator and other MCH/CSHCN epidemiologists provide the foundation, tools and structure to assure the MCH and CSHCN programs access to policy and program relevant data.

The Louisiana SSDI project focuses on improving the data/epidemiologic capacity of Louisiana's MCH and CSHCN programs to address MCH relevant health problems and outcomes. The main goals of SSDI are to: (1) improve data linkages, analyses, and dissemination utilizing birth records linked with infant death records, Medicaid eligibility files, WIC eligibility files, newborn screening data, PRAMS data, Louisiana hospital inpatient discharge data, and birth defects surveillance data; and (2) maintain access to and analyze data from the Caring Communities Youth Survey (CCYS). This bi-annually collected survey provides opportunities to better understand the risk and protective factors and behaviors of Louisiana youth. The SSDI project is responsible for maintaining all MCH related datasets obtained through the various programs and assuring that the MCH program has access to the most recent data available for each data source.

From the linked data, surveys, and registries, MCH/CSHCN epidemiologists conduct analyses and program evaluations that provide relevant information to program staff and policy makers. This information is used to help the state prioritize needs and resources for developing programs and interventions to improve performance on national and state goals. The MCH/CSHCN epidemiologists work with program coordinators, providers, and other stakeholders to share information obtained from the analysis of surveillance data, linked data sets, and other MCH relevant surveys, and to seek program input on policy implications of results.

Analytic results are disseminated at the local, state, and national levels in the form of 1) presentations to the Louisiana Perinatal Commission, MCH Coalition, and internal and external meetings and conferences (e.g., CDC MCH EPI conference), 2) publications in peer reviewed journals (e.g., Louisiana State Medical Society Journal and Maternal and Child Health Journal), and Louisiana Morbidity Report and 3) MCH data profiles and MCH data book on the DHH/OPH/MCH website.

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

DATA SOURCES	**Does your state participate in the YRBS survey? (Select 1 - 3)**	**Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)**
Youth Risk Behavior Survey (YRBS)	1	No
Caring Community	3	Yes

Youth Survey (CCYS)		

Notes - 2011

Narrative:
Because the response rate of the Louisiana YRBS over the last several years has been inadequate, MCH will continue using tobacco use data obtained in the Communities that Care Youth Survey (CCYS). This survey is conducted by the state Office of Addictive Disorders every two years and provides parish specific data on a number of adolescent risk behaviors, including tobacco use. According to the 2008 CCYS, the percent of adolescents in grades 8 through 12 who reported using a tobacco product in the past month increased to 21.1% from 20.5% in 2006. Although this represents an increase, the percentage remains lower than the 23.7% reported in 2004. Nationally in 2007, 20% of high school students were current cigarette smokers, 13.6% were cigar smokers, and 7.9% were smokeless tobacco users.

As a public health measure to address tobacco use, the Adolescent School Health Program includes tobacco use as a core sentinel condition in its continuous quality improvement (CQI) program. Each SBHC is required to undergo a rigorous on-site CQI review on a rotating basis, usually once within a 3 year period. During the review, charts are audited randomly and evaluated on whether providers ask students about tobacco use and provide appropriate prevention and/or cessation counseling. In 2008-2009, 6 sites underwent a CQI review. For students receiving a comprehensive exam, 100% of charts audited had documentation of a tobacco screening and, if necessary, counseling to address tobacco use.

Many SBHCs provide tobacco prevention programs at their schools. In addition, OPH has a Tobacco Control Program with many initiatives to decrease tobacco use, including efforts to change environmental policies

This Health Systems Capacity Indicator serves as a monitoring tool that will help Louisiana focus its resources on continued efforts to bring down the percent of adolescents who use tobacco products. By reducing the proportion of adolescents and young adults who use tobacco products, Louisiana can prevent the resultant morbidity and mortality of this risk behavior.

IV. Priorities, Performance and Program Activities

A. Background and Overview

Through extensive quantitative and qualitative analyses of the 2010 MCH Needs Assessment, leading priority needs for MCH and CYSHCN populations were determined while also assessing local, regional, and state capacity to address these priorities. Since the 2005 Needs Assessment, the 2010 needs assessment showed improvements in access to prenatal care and in insurance coverage for women, infants, children, and CYSHCN. MCH concerns for racial disparities in infant mortality; injury morbidity/mortality; behavioral health; and oral health, persist as do the CYSHCN concerns for medical homes, access to comprehensive healthcare, limited availability of Medicaid providers, and transportation services. New priorities include the need for MCH to address obesity prevention and inter-conception care with chronic disease management; and for CSHS to address gaps in care coordination and transition services for CYSHCN.

Louisiana's 10 Priority Needs for 2010-15 are: (1) Decrease infant mortality through the reduction of preterm births in the African-American population; (2) Decrease intentional and unintentional injuries in the maternal, child, adolescent, and children with special health care needs populations; (3) Improve preconception and inter-conception health among Louisiana women; (4) Reduce unintended pregnancies and reduce births spaced less than 24 months apart; (5)Increase care coordination statewide for CYSHCN and their families; (6) Improve the nutritional health of the maternal and child population with a focus on obesity prevention and breastfeeding; (7) Assure that strategies and methods in MCH programming are culturally competent to reduce racial disparities; 8) Improve oral health of MCH population by increasing access to preventive measures and access to oral health care; (9) Improve the behavioral health of the MCH population through prevention, early intervention, screening, referral, and treatment where appropriate; (10) Increase preventive services for adolescents and transition services for adolescents with special health care needs.

The continuing State Performance Measures are: (SPM 1) Percent of all children/adolescents enrolled in public schools in Louisiana with access to School Based Health Center services; (SPM 3) Rate (per 1,000) of children <18 who've been abused/neglected; (SPM 6) Percent of women giving birth who undergo screening for substance abuse, depression and domestic violence using Screening, Brief Intervention, Referral and Treatment (SBIRT) approved methods; (SPM 7) Percent of women who use alcohol during pregnancy. The new State Performance Measures for 2010-15 are: (SPM 2) Percent of unintended pregnancies among women who had a live birth; (SPM 4) The difference in the percent of publicly insured and percent of privately insured CYSHCN in Louisiana who need more care coordination services; (SPM 5) Percent of late preterm births; (SPM 8) Percent of African American women who most often lay their baby on their back to sleep; (SPM 9) Percent of women who visited a healthcare worker to be checked or treated for high blood pressure during the 12 months before pregnancy; and (SPM 10) Percent of women delivering a live birth in less than 24 months of a previous live birth.

Compared to 2005 data, 2007 data for National Performance Measures (NPMs) and State Performance Measures (SPMs) showed improvements in newborns who screened positive for the newborn screening program conditions, with timely follow-up (NPM 1), infants breastfeeding at 6 months (NPM 11), newborns with hearing screens before discharge (NPM 12), women smokers in last 3 months of pregnancy (NPM 15), pregnant women using alcohol (SPM 7), Very Low Birth Weight infants delivered in facilities for high risk neonates (NPM 17), suicide rates of 15-18 years (NPM 16), and Fetal Infant Mortality Reviews (SPM 9). Compared to 2005 data, 2008 data showed improvements in 19-35 month old children with full age appropriate immunizations (NPM 7) and Louisiana public school students with access to School Based Health Center services (SPM 1). Compared to 2005 data, 2009 data showed improvements in 3rd graders with sealants (NPM 9), WIC children 2-5 years with BMIs >85th percentile (NPM 14) and CYSHCN with case management follow-up (SPM 4).

Compared to 2005 data, 2007 data for National Performance Measures (NPMs) and State Performance Measures (SPMs) worsened for birth rates for teens (NPM 8), motor vehicle death rate of children <14 years (NPM 10), uninsured children <18 years (NPM 13). [No new data for NPMs 2-6 since 2005-06; SPM 5 is now NPM 14, and SPM 6 and 10 are no longer reported.]

Compared to 2005 data, the 2007 and/or 2008 data stayed the same for infant births to women with 1st trimester prenatal care (NPM 18), women who received publicly-funded family planning services (SPM 2), rates of abused/neglected children <18 years (SPM 3), and Sudden Infant Death Syndrome rate (SPM 8).
The 2010-15 Priority Needs reflect Louisiana's leading/emerging health issues impacting MCH and CYSHCN populations. MCH will ensure evidence-informed strategic planning and resource allocation that address the new priority needs to improve performance measures, and ultimately health outcomes.

B. State Priorities

Priority Need 1. Decrease Infant mortality through reduction of preterm births in the African American population.

NPM's 8, 15, 17, and 18 are linked to priority need 1. NPM 8 measures the birth rate for teenagers aged 15 through 17. Teens have higher rates of premature birth than women over 20. In Louisiana, the teen birth rate among African American's is nearly 2 times higher than that of whites. Because prematurity increases the risk of infant death, monitoring the teen birth rate is important in planning efforts to reduce infant mortality among African Americans. NPM 15 measures the percentage of women who smoke in the last three months of pregnancy. National performance measure 18 was selected because it provides an assessment of whether prenatal care is initiated early in pregnancy, increasing the likelihood of positive birth outcomes. NPM 17 measures the percent of very low birth weight infants delivered at facilities for high risk deliveries and neonates. This performance measure was linked with priority 1 because increasing the percentage of low birth weight deliveries at facilities with staff who have specialized training and technology to care for very low birth weight infants decreases the risk of infant death. SPM 5 measures the percent of late preterm births, those occurring at 34-36 weeks gestation. SPM 6 measures the percentage of women giving birth who have been screened for substance use, depression and domestic violence. SPM 7 measures the percent of women who use alcohol during pregnancy. These have all been shown to have a negative effect on birth outcomes. SPM 8 measures the percent of African American women who most often lay their baby on their back to sleep.

MCH staff and contracts dedicated to reducing infant mortality and preterm births include Maternal Health Medical Director, Nurse Consultant, Health Communication Coordinator, four Epidemiologists, two program managers, nine regional nurse coordinators of the Fetal Infant Mortality Review program and a contract for the social marketing campaign Partners for Healthy Babies. Other contracts with Healthy Start agencies and Office of Addictive Disorders address preterm prevention.

Priority Need 2. Decrease intentional and unintentional injuries in the maternal, child adolescent and CYSHCN populations.

NPM's 10, 16 and SPM 3, 6 and 8 were linked to priority need 2. NPM 10 assesses the rate of deaths to children aged 14 years and younger caused by motor vehicle crashes. This measure was linked to priority need 2 because motor vehicles are the leading external cause of injury related mortality among children. NPM 16 measures the rate of suicide deaths among youth ages 15 to 19. Suicide is the third leading cause of injury related mortality among children in this age range. SPM 3 measures the rate of children under 18 who have been abused or neglected. This performance measure was selected as a result of data which show that nearly 10% of children in

Louisiana are reported to be abused or neglected. SMP8 measures the percent of African American women who most often lay their baby on their back to sleep. SPM 6 measures the percentage of women giving birth who have been screened for substance use, depression and domestic violence.

MCH staff and contracts dedicated to injury prevention include Child Health Medical Director, two program managers, nine regional Child Safety Coordinators, three injury prevention program managers, two epidemiologists, over 100 Nurse Family Partnership nurses addressing intentional and unintentional injury, and a contract for social marketing campaign addressing safe sleep environments for infants.

Priority Need 3. Improve preconception and interconception health among Louisiana women.

NPM 15 and SPM's 7 and 9 were linked to priority need 3. NPM 15 and SPM 7 assess the percent of women who smoke and drink in the last trimester of pregnancy respectively. As such they provide an assessment of the risky behaviors among women during pregnancy. SPM 9 measures the percent of women who visited a healthcare worker to be checked or treated for high blood pressure during the 12 months before pregnancy. This performance measure was linked to priority need 3 as it is a direct measure of the health of women prior to pregnancy.

MCH staff and contracts dedicated to preconception and interconception health include Maternal Health Medical Director, Nurse Consultant, Health Communication Coordinator, four Epidemiologists, two program managers, nine regional nurse coordinators of the Fetal Infant Mortality Review program and a contract for the social marketing preconception health The Stork Reality. A new initiative at the Department of Health and Hospitals (DHH) to improve birth outcomes will allow for more resources to address this important area of unmet need. DHH is implementing a new managed care system, Coordinated Care Networks that includes care coordination for postpartum women with chronic conditions and preterm delivery that will cover the interconception period.

Priority Need 4. Reduce unintended pregnancies and reduce births spaced less than 24 months apart.
SPM 2 measures the percent of unintended pregnancies among women who had a live birth. SPM 2 is linked to priority need 4 because it provides a direct measure of pregnancy intention. SPM 10 measures the percent of women delivering a live birth in less than 24 months of a previous live birth.

MCH provides funding for OPH Family Planning Program infrastructure at local and state health department. Four MCH epidemiologists address this subject and one is responsible for the Family Planning Medicaid Waiver evaluation. A contract for the social marketing preconception health The Stork Reality educates the public on the high unintended pregnancy rate. The MCH funded Nurse Family Partnership Program is a proven to increase pregnancy spacing.

Priority Need 5. Increase care coordination for CYSHCN and their families.

SPM 4 measures the discrepancy between publically and privately insured CYSHCN who have unmet need for care coordination. NPM 2 measures the percent of children with special health care needs age 0 to 18 whose families partner in decision-making at all levels and are satisfied with the services they receive. NPM 3 measures the percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. NPM 5- The percent of children with special health care needs age 0 to 5 whose families report the community-based service system are organized so that they can use them easily.

CSHS central office staff include the director who is a board certified developmental pediatrician, a nurse consultant with over 30 years experience with CYSHCN, a social worker specializing in CYSHCN, a nurse certified case manager, a nutritionist, an audiologist who directs the hearing,

speech, and vision program (HSV), and parent consultants for both the CSHS and HSV programs, and a strong epidemiology section. The Newborn Hearing Screening Program and the Louisiana Birth Defects Monitoring Network are programs within CSHS, permitting early identification of infants born with hearing loss and infants with birth defects for provision of care coordination. Parent liaisons contracted from Families Helping Families in all CSHS clinics meet with families to identify need for community resources. Collaboration with F2FHICs provides additional support for parent liaisons and families with CYSHCN requiring access to care coordination resources. CSHS provides financial incentives for MH's to designate a care coordinator, and provides technical assistance to practices through its nurse certified case manager and social worker. CSHS trains all pediatric residents from both medical schools in the role of MH in care coordination and in public health and community resources. CSHS has formed a new stakeholder advisory group with representatives from all public health programs from both Department of Health and Hospitals (DHH) and the Department of Social Services (DSS) that provide services for CYSHCN and their families, permitting improved coordination between programs. CSHS participates in a DSS-DHH data integration project to make public health services easier to access for families by providing single point of entry into multiple programs.

Priority Need 6. Improve the nutritional health of the maternal and child population with a focus on obesity prevention and breastfeeding.

NPM's 11 and 14 were linked to priority need 6. NPM 11 assesses the percentage of mothers who breastfeed their infants at 6 months of age. This performance measure was linked to priority need 6 because it provides an assessment of breastfeeding duration. NPM 14 measures the percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index at or above the 85th percentile. This measure provides insight into the percentage of obese children receiving WIC services. As such, this performance measure provides information important to developing interventions early in development that may stem the tide of obesity later in life.

MCH staff and contracts dedicated to nutritional health include an MCH Registered Dietician, a program manager of the breastfeeding promotion program in delivery hospitals, the Maternal and Child Health Medical Directors, the social marketing campaign Partners for Healthy Babies, the WIC Program, Louisiana Obesity Council, and collaborative initiatives with Tulane University School of Public Health and Louisiana State University (LSU) School of Public Health. A contract is being developed with LSU to establish an early childhood obesity prevention program through child care centers and the Louisiana Department of Social Services who administers child care quality assurance and licensing.

Priority Need 7. Assure that strategies and methods in MCH programs are culturally competent to reduce racial disparities.

SPM 8 was linked to Priority Need 7. It measures the percentage of African American women who most often lay their baby on their back to sleep. This measure assess MCH's efforts to increase back sleeping among the African American population through targeted initiatives including the Safe Sleep social marketing campaign.
MCH contracts and staff dedicated to providing culturally relevant and appropriate resources include the Partners for Health Babies and Safe Sleep social marketing campaigns, Nurse Family Partnership program, tobacco control initiative, child care health consultant initiative, and obesity prevention initiative. In addition, MCH staff and contracts dedicated to assuring cultural competency of its programming include four epidemiologists who provide the race specific data and analyses that guide program development.

Priority Need 8. Improve oral health of MCH and CYSHCN populations by increasing access to preventive measures and access to oral health care.

NPM 9 was linked to priority need 8. NPM 9 measures the percent of third grade children who received protective sealants on at least one permanent molar tooth. This variable is a standard

oral health measure collected by the state oral health program and used to examine the oral health of children. It is also a measure collected across states allowing for cross state comparisons.

MCH staff and contracts dedicated to oral health include two program managers, an epidemiologist, a health educator, fluoridation engineer, an Oral Health Advisory Council, and contracts for dentists and dental hygienists to apply dental sealants in elementary schools.

Priority Need 9. Improve the behavioral health of MCH and CYSHCN populations through prevention, screening referral, and treatment, where appropriate.

NPM 15 and SPM's 6 and 7 were linked to priority need 9. NPM 15 and SPM 7 measure the percentage of women who smoke and drink in the last 3 months of pregnancy respectively. These performance measures provide some indication of the extent to which behavioral health services and interventions are needed. SPM 6 measures the percent of Louisiana women giving birth who are screened for substance use, depression and domestic violence using SBIRT. This particular measure was selected because it provides an assessment of the magnitude of behavioral problems that affect Louisiana women.

MCH staff and contracts dedicated to behavioral health include Maternal Health Medical Director, Child Health Medical Director, Mental Health Coordinator (LCSW), Maternal Health Nurse Consultant, Health Communication Coordinator, four Epidemiologists, two program managers, a state Medical Director and state coordinator and nine regional coordinators of the Screening, Brief Intervention, Referral and Treatment program, a contract for the social marketing campaign Partners for Healthy Babies, six contracts for mental health professionals throughout the regions, Early Childhood Comprehensive Systems director and coordinator addressing social and emotional health. The Nurse Family Partnership program targets behavioral health and MCH funds a Clinical Director with PhD in Psychology, Program Manager, State Nurse Consultant, two Regional Nurse Consultants, Contract Monitor, and over 100 nurse home visitors.

Priority Need 10. Increase preventive services for adolescents and transition services for youth with special health care needs.

NPM 6 and SPM 1 were linked to priority need 10. NPM 6 measures the percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence. This measure comes from the CYSHCN survey and is worded to be identical to priority need 10. SPM1 measures the percent of all children and adolescents enrolled in public schools in Louisiana that have access to school based health center services. This measure was linked to priority need 10 because it provides some data on the extent to which preventive services are available in school based health centers. As such it is also an indirect assessment of preventive services needed.

School Based Health Clinics provide preventive and acute healthcare for youth in elementary and high schools throughout the state. The OPH Adolescent School Health Program (ASHP) provides training and technical assistance to all 62 SBHC sites. SBHCs are required to coordinate care with the student's PCP/medical home. SBHC sites are SCHIP/Medicaid application centers. Medicaid outreach to enroll students has decreased the percent of students without health insurance to 8% in 2008-2009. Partners for Healthy Babies and Stork Reality conduct social marketing campaigns to improve reproductive health. The Nurse Family Partnership Program targets young mothers with a median age among program participants of 19 years.

CSHS has a long history of providing care coordination and transition services for YSHCN in CSHS subspecialty clinics. A new pilot in Regions 1 and 6 provides transition services using web-based software to develop a care plan for youth with more complex needs. The transition program will be expanded to at least two other regions in 2011. CSHS will augment transition

services in private practices through its MH initiative placing coordinators in private practices and teaching clinics. CSHS will add components of transition to its MH didactic sessions with LSU and Tulane pediatric residents and will place articles on transition in the AAP and LAFP newsletters. Finally, collaboration with the Louisiana Rehabilitation Services Independent Living Program and Vocational Rehabilitation Program will be increased through the new CSHS stakeholder group. CSHS will contract with FHF to train public health regional program staff that serve CYSHCN to refer to each other's programs. Finally, the DHH-DSS Data Integration Project will help to facilitate this by providing information regarding linkage and eligibility for all appropriate public health programs in the two agencies.

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	95	99	99	99	100
Annual Indicator	96.0	99.1	97.9	98.8	99.3
Numerator	120	116	137	159	143
Denominator	125	117	140	161	144
Data Source				Louisiana Genetics Database	Louisiana Genetics Database
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	100	100	100	100	100

Notes - 2009
Data is for calendar year.

Notes - 2008
Data is for calendar year.

Notes - 2007
Data is for calendar year.

a. Last Year's Accomplishments
Population Based Services
In 2009, newborns screens were conducted on 61,138 infants in Louisiana. Based on newborn population estimates of 65,000 for 2009, this represents a screening rate of 94%.

Table 1 in the Attachments indicates the number of infants detected with the diseases included in

the newborn screening battery from 2005 through 2009. Of all the infants screened in 2009, 144 infants had a confirmed diagnosis of a genetic disease. Year to year, sickle cell disease and congenital hypothyroidism are the two most often diagnosed heritable conditions. Tandem mass spectrometry continues to play a prominent role in the state's ability to screen for numerous metabolic disorders. Although metabolic disorders make up 10% of presumptive positive results on the newborn heel stick screen, this methodology has improved the state's ability to play a vital role in preventing some of the debilitating effects of some of these genetic conditions.

The Genetics Section is working to ensure that greater than 95% of newborns are screened for all the diseases on the official battery by providing education to medical providers on the legislation and rule mandating screening, proper bloodspot collection techniques and by only allowing Office of Public Health (OPH) approved laboratories to perform the tests on newborns. The project of matching newborn screening records with birth records was conducted in 2008 with 2006 data and in 2009 using 2007 data. The results of this match will be used to evaluate hospitals on their newborn screening rates.

The Genetics Program is also working to ensure that all infants who are presumptive positive for a genetic condition on the newborn screen receive timely and appropriate follow-up. The program monitors these children until a diagnosis is confirmed. As indicated in the Data Objectives, 99.3% of screen positive newborns received timely follow up to definitive diagnosis and clinical management. Prematurity may cause a delay in obtaining a definitive diagnosis in some infants. Medical staff must focus on maintaining a premature infant's viability before presumptive positive genetic conditions can be addressed. The Genetics staff follow the progress of these infants until further testing on the presumptive condition is done and a final diagnosis is made.

Direct Services
The Genetics Program continued to contract with medical geneticists, endocrinologists, hematologists, and pulmonologists to conduct specialty clinics at over ten sites reaching over 500 families, ensuring early detection and initiation into specialized care.

Enabling Services
Contracts were continued with Sickle Cell Foundations in 7 regions to provide patient assistance to families affected by sickle cell disease.

Infrastructure Building Services
Although most of the newborn screening testing returned to the state laboratory in November 2007 after Hurricane Katrina, DNA testing for Cystic Fibrosis was outsourced to a private laboratory. This portion of newborn screening returned to the state laboratory in June 2008 and has reduced the time between collection of a newborn screen and the release of results. This has allowed Genetics to contact providers sooner regarding abnormal results. Follow-up coverage after hours and on week-ends is also critical to the infrastructure of the program.

The Louisiana Newborn Screening Advisory Committee (LANSAC) continued to meet to discuss the impact of the adoption of the American College of Medical Genetics' core panel and newborn screening policy issues. Also, the ad hoc committees such as the Metabolic Advisory Group and the Cystic Fibrosis Advisory Group continue to meet to discuss issues that pertain to these conditions.
An attachment is included in this section.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Conduct universal newborn screening and follow-up for 29 conditions.			X	

2. Conduct training sessions at hospitals to reduce unsatisfactory screening specimens.				X
3. Conduct regional genetics clinics at 10 sites staffed by a medical geneticist.	X			
4. Provide clinic-based wrap-around services by contracted sickle cell foundation staff.		X		
5. Conduct a pilot study on newborn screening for Severe Combine Immunodeficiency Syndrome (SCID).			X	
6. Provide an educational program for sickle cell patients and families.		X		
7. Provide an educational program for medical providers on metabolic diseases detected through tandem mass spectrometry.				X
8. Develop protocols for NICU staff for timing of rescreening Enhance program website as medical providers use it as the source for current information on NBS.				X
9.				
10.				

b. Current Activities

Direct Services and Enabling Services

Genetics Program continues to conduct regional genetics clinics for evaluation and counseling. Since the expansion of the newborn screening panel, these clinics have become important for referral of metabolic patients. Contracts are also in place for medical evaluation and consultation for Cystic Fibrosis, endocrine disorders (Congenital Hypothyroidism and Congenital Adrenal Hyperplasia) and for supportive services with regional sickle cell foundations.

Population-Based Services

The core panel recommended by the American College of Medical Genetics continues serve as the basis for newborn heel stick screening. The Genetics Program is in collaboration with the state laboratory and Children's Hospital in New Orleans to initiate a pilot study on testing for Severe Combined Immunodeficiency Syndrome (SCID) on the newborn screening panel.

Infrastructure Building Services

After testing returned to the state laboratory after Hurricane Katrina, the state laboratory did not test unsatisfactory samples due to concerns regarding restriction through Clinical Laboratory Improvement Amendments (CLIA) regulations. The Genetics Program has worked with the laboratory and CLIA to test unsatisfactory samples in order to prevent potential presumptive positives from being missed.

The Genetics Program is developing an in-service to assist hospitals with high unsatisfactory specimen collection rates on proper collection techniques.

c. Plan for the Coming Year

Objective: Increase to 98% the percent of newborns who are screened and confirmed with condition(s) mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies). The program will work with the Newborn Screening Advisory Committee to identify facilities with low testing rates and to develop methods for helping these facilities increase their testing rates.

Direct and Enabling Services

The Genetics Section will ensure the provision of specialized medical and nutritional management for 100% of affected infants identified through newborn screening. Genetics will continue to contract with medical schools to provide consultation for patients identified through

the expanded screening.

Population-Based Services
The Genetics Section will review the current panel of the ACMG core panel and participate in discussions on new conditions that might be added to the panel. The program will implement SCID pilot testing in conjunction with the state laboratory and Children's Hospital in New Orleans.

Infrastructure Building Services
The Genetics Program is working with the Southeast Sickle Cell Center at Tulane Health Sciences Center to establish a system for trait testing and counseling contingent on funding from a grant from the CDC. The program will continue to meet with stakeholders to develop a plan for transitional and adult care, and to address improvements in the current regional pediatric sickle cell system.

The Genetics Program will use data from the match with birth records to determine the testing rates at hospitals. The program will counsel facilities with low testing rates to determine barriers to testing and to help improve their testing rates.

The Genetics Program will continue to work with the state laboratory and to submitters to reduce the rate of unsatisfactory sample submission. The Genetics Program and the state laboratory are developing in-service training for submitters for newborn screening to address proper collection techniques. These in-services will take place in the top 5 of the 9 regions across the state identified as having the highest unsatisfactory sample submission rates.

The Genetics Section will convene the Newborn Screening Advisory Committee to review the data from newborn screening and to address emerging issues such as new testing methodologies and new conditions recommended by the ACMG .

Website enhancements will be made to provide a venue for improving the knowledge level of medical providers on newborn screening topics.

Form 6, Number and Percentage of Newborns and Others Screened, Cases Confirmed, and Treated

The newborn screening data reported on Form 6 is provided to assist the reviewer analyze NPM01.

Total Births by Occurrence:	**65017**					
Reporting Year:	**2009**					
Type of Screening Tests:	**(A) Receiving at least one Screen (1)**		**(B) No. of Presumptive Positive Screens**	**(C) No. Confirmed Cases (2)**	**(D) Needing Treatment that Received Treatment (3)**	
	No.	%	No.	No.	No.	%
Phenylketonuria (Classical)	61138	94.0	20	1	1	100.0
Congenital Hypothyroidism (Classical)	61138	94.0	845	48	47	97.9
Galactosemia	61138	94.0	48	8	8	100.0

(Classical)						
Sickle Cell Disease	61138	94.0	68	68	68	100.0
Biotinidase Deficiency	61138	94.0	4	1	1	100.0
Cystic Fibrosis	61138	94.0	72	6	6	100.0
Very Long-Chain Acyl-CoA Dehydrogenase Deficiency	61138	94.0	21	1	1	100.0
Citrullinemia	61138	94.0	4	1	1	100.0
Carnitine Uptake Defect	61138	94.0	20	1	1	100.0
Glutaric Acidemia Type I	61138	94.0	10	2	2	100.0
21-Hydroxylase Deficient Congenital Adrenal Hyperplasia	61138	94.0	63	5	5	100.0

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	60	60	62	65	65
Annual Indicator	55.2	55.2	62.2	62.2	62.2
Numerator					
Denominator					
Data Source				National Survey of CSHCN	National Survey of CSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	65	65	70	70	70

Notes - 2009
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

a. Last Year's Accomplishments
Direct and Enabling Services
Parent Liaisons worked with CSHS staff in all 9 regional clinics to provide families/YSHCN with the information and support they needed to be active partners in decision-making. PLs provided one on one support in CSHS clinics, through telephone encounters and by accompanying families to meetings, when requested. PLs disseminated resource information to families during CSHS clinic visits and maintained an up to date inventory of available community resources through on-going review. PLs informed families of CYSHCN of upcoming training activities and educational opportunities and linked them to disease specific support groups. PLs assisted families with completing applications for other resources, as needed.

Population Based Services
PLs performed community outreach and participated in health and information fairs. PLs conducted support groups and trainings in community settings based on the interests of families of CYSHCN. PLs referred families to Information Specialists at regional F2FHICs to provide additional information on state and national resources. The CSHS website maintained an ongoing list of regional, state and national support resources for families, including website highlights for Spanish-speaking families. Family Matters, a statewide newsletter, was published quarterly and contained information on services, regional activities and educational information for CYSHCN and families. Family Matters was posted on the CSHS website and disseminated in FHF regional offices.

Infrastructure Building
CSHS employed a Statewide Parent Consultant, Parent Training Coordinator and regional PLs to provide the parent perspective in policy and program-related decision- making and to ensure that families had access to every possible resource to be active partners in decision-making for their CYSHCN. PLs attended at least 16 hours of training offered by CSHS. The Parent Consultant and Parent Training Coordinator conducted orientation with new PLs before beginning work in CSHS regional clinics. They conducted four trainings for PLs statewide. Topics included information on changes to IDEA and 504 accommodations, care coordination and transition, networking and medical home. PLs statewide served on numerous boards and committees, providing insight to assist policy and services that impact the lives of CSHCN and their families.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide funding for CSHS staff and Parent Liaisons in all CSHS offices.	X	X	X	X
2. Employ parents of CSHCN of different ethnicities and knowledge of local issues.	X	X	X	X
3. Provide direct support services to all families attending CSHS clinics.	X	X		
4. Update regional resource manuals.	X	X	X	
5. Publish Family Matters newsletter quarterly.			X	
6. Provide quarterly trainings for PL staff.		X	X	
7. Provide support to families of CYSHCN through local trainings, workshops and health fairs.	X	X	X	
8. Work with F2F HICs to coordinate services.			X	

9. Update CSHS website to reflect current resource information and opportunities.			X	
10. Include parents in policy decision making at all levels.				X

b. Current Activities

Direct and Enabling Services

CSHS PLs provide information, referral and support services in all CSHS regional clinics. PLs and CSHS social service staff link families to community resources and encourage families to be active partners in decision-making.

Population Based Services

CSHS regional staff collaborate with schools, hospitals, Office of Mental Health, Office for Citizens with Developmental Disabilities and private physician practices to enhance coordination of information and services. PLs assist parents in accessing services through community partnerships and agency collaborations. PLs give presentations to community and parent groups about the needs of CYSHCN and their families. The CSHS website is updated to reflect new linkages and current information for families. The Family Matters newsletter is published quarterly and disseminated to families in CSHS clinics and posted to the CSHS website.

Infrastructure Building Services

CSHS employs a Statewide Parent Consultant, Parent Training Coordinator and PLs in every region of the state to provide a parent perspective in CSHS policy at the local and state levels. Quarterly trainings for PLs are ongoing.

c. Plan for the Coming Year

Objective: To increase to 65% children with special health care needs age 0-18 whose families partner in decision making at all levels and are satisfied with the services they receive.

Direct and Enabling Services

CSHS will employ PLs for all regional clinics to assist parents with accessing services and provide emotional support, information and referral. PLs will provide self-advocacy skills information on how to deal with insurance companies to CSHS patients and families.

Population Based Services

The CSHS website will be updated on an ongoing basis with the most current linkages to resources and information for CYSHCN and families. The Families Matters newsletter will continue its publication and add a column with tips on self-advocacy skills. The newsletter will continue its dissemination in regional FHF offices and on the CSHS website. PLs will continue to disseminate community resource information and educational materials to CYSHCN and families during outreach events and health and information fairs. PLs will continue to provide workshops, presentations and trainings to professionals, CSHCN and families.

Infrastructure Building

CSHS will continue to employ a Statewide Parent Consultant and Parent Training Coordinator to provide support and training to regional PLs. CSHS will contract with a social marketing firm for consulting services regarding a plan to inform families of how to contact regional FHF offices for help with accessing information and services for CYSHCN.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	50	50	55	55	55
Annual Indicator	48.8	48.8	49.6	49.6	49.6
Numerator					
Denominator					
Data Source				National Survey of CSHCN	National Survey of CSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	55	55	55	55	55

Notes - 2009
The data reported in 2009 are pre-populated with the data from 2007 for this performance measure.

Notes - 2008
The data reported in 2008 are pre-populated with the data from 2007 for this performance measure.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

a. Last Year's Accomplishments
Direct and Enabling Services
CSHS sub-specialty clinics continued in all 9 regions of the state. Teams consisting of physician, nurse, social worker, social service counselor, and parent liaison provided medical care, care coordination, parent support, and transition services. 98% of children coming to the clinics were linked with a primary care physician (PCP). PCPs received a consultation letter after every visit. Several clinics were cancelled due to low volume, particularly in region I where providers take Medicaid and Children's Healthcare Assistance Program covers services at Children's Hospital for uninsured families making < 350% of the FPL. Despite this, the number of children in CSHS clinics increased for the first time in many years as follows: 2007: 4645 CSHCN; 2008: 4421 CSHCN; 2009: 4515CSHCN. The number of service encounters increased from 17,874 in 2007 to 19,025 in 2008 to 20,780 in 2009. Hiring freezes and lay-offs resulted in loss of an audiologist, a social worker, and two part time nurse positions, leaving two CSHS audiologists for the entire state. The CSHS application was simplified and changed to mail-in. CSHS held a retreat to begin revision of its pre-computer clinic policy manual. CSHS care coordination (CC) pilot in Region I for youth in transition using new web-based software was expanded to Region 6 (Alexandria) in May 2009 and simplified due to staff shortages from continued hiring freezes. Transition care plans for CSHCN with more complex needs were mailed to the medical home (MH) with the clinic notes.

Population Based Services
CSHS participated in the DHH-DSS data integration project to create a master patient database

accessible by programs from both agencies. The program will indicate which programs clients were linked to and which programs they are eligible for.
CSHS hired a Care Coordinator Supervisor in April 2009 to train and manage the CC program for pediatric offices. She is supervised by the CSHS social worker who was hired soon after, filling a vacancy created in December 2008. CSHS continued to fund a social worker care coordinator in a large public hospital clinic in Baton Rouge and a care coordinator for the LSU Continuity Clinic (Tigercare) in New Orleans. This position was vacant for most of 2009. A Spanish/English speaking care coordinator was hired in November 2009. Over 30 clinics in Region 1 became NCQA certified MH's as a result of a HRSA funded Primary Care Access and Stabilization Grant, including Tigercare. CSHS helped the Baton Rouge clinic to became NCQA certified soon after. The contract for a large rural practice in Bogalusa was ended after five years because CC would continue without the contract. Training materials for care coordinators were developed.

Infrastructure Building Services
The CSHS Director and CSHS Care Coordinator Supervisor continued to be on the state's Advisory Board for the Healthcare Quality Forum (LHCQF) MH Committee, which is a legislated stakeholder group to advise the administration on health care reform. The proposed reform model is based on the MH, incorporating an enhanced reimbursement for CC and a conversion from fee for service to CC Networks, which would function like HMO's. A Medicaid Waiver for this change was submitted to CMS in December 2007 but is still pending approval. A new CSHS policy was implemented in July 2008 to discharge youth with CF at age 21 with other coverage and to limit CSHS coverage to clinic visits and four classes of lifesaving medications. Other health insurance coverage was identified for most youth, and the policy change resulted in savings of close to $100,000, intended to be used for new CC contracts. Most of this was taken from the budget in midyear and year end cuts totaling $800,000, or all of the state supplemental funding. All Tulane and LSU residents completing their developmental rotations (directed by the CSHS director) were trained in MH. By incorporating MH into resident training and putting care coordinators in teaching clinics CSHS hopes to inspire new pediatricians to incorporate MH principles into their future practices.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide subspecialty care in shortage areas. Update policy manual.	X			
2. Link CSHCN in CSHS clinics to medical homes and send copies of subspecialty consults.		X	X	
3. Provide transition services for adolescents.		X		
4. Provide care coordinators to pediatric and family practice teaching clinics.		X	X	X
5. Participate in DSS Data Integration project to improve care coordination for CSHCN.			X	X
6. Work with CSHS stakeholder group to increase coordination between public health programs.				X
7. Work with administration and Medicaid to improve reimbursement for care coordination in medical homes by demonstrating effectiveness.				X
8. Participation in state HCQF Medical Home Advisory Group.				X
9. Incorporate medical home model into LSU and Tulane pediatric and LSU family practice resident training.				X
10. Collaborate with AAP in MH Healthcare Reform policies.				X

b. Current Activities

Direct and Enabling Services
Subspecialty clinics in each region address provider shortages. CSHCN are linked to MHs, who receive copies of care plans and sub-specialty clinic notes. CC in CSHS clinics focusing on transition continues in regions I and VI.

Population Based Services
The DHH and DSS Integration Project is currently stalled by administration. The care coordinator in Tigercare has expanded CC to a second Region 1 teaching clinic serving a Latino population. The Baton Rouge clinic developed a software system for CC in MH's that will expanded to Tigercare and if successful, to other clinics with CC. Laminated one page region-specific resource guides were developed for quick reference and mailed to pediatricians who completed the Needs Assessment MD survey. Resource guides were sent to CSHS clinics and care coordination clinics, and posted on the CSHS website. A new stakeholder group has formed to improve coordination between public health programs.

Infrastructure Building
Two papers have been accepted by MCH Journal on effectiveness of CC at Tigercare post-Katrina and on racial and geographic disparities in receipt of transition services. The CSHS Director and the Statewide Care Coordinator Supervisor continue on the Advisory Board for the LHCQF MH committee. CSHS is working with administration and Medicaid to incorporate CC into healthcare reform and ensure reimbursement for CC in MH's.

c. Plan for the Coming Year
Objective: to increase the % CSHCN in LA with a MH to 55%. (National CSHCN Survey 2010).

Direct and Enabling Services
In the 2006 CSHCN survey, LA was above the national average for this NPM (49.6% vs 47.1% US). The LA cluster had higher % CSHCN receive primary care from a doctor's office (85.9% LA vs 80.9% US), fewer problems obtaining referrals (83.4% vs 78.4%), and higher % receiving care coordination (77.2% vs 73.0% US), which is improved from the 2001 survey. % YSHCN receiving transition services is less than the US average. Therefore CSHS will continue its new CC pilot in Regions I and VI focusing on transition and expand to Region IV (Lafayette) and at least one other region. CSHS sub-specialty clinics will continue to address provider shortages. Clinics with less than 10 patients will be closed. CSHS will continue to link CSHCN with MH's and to send consultant letters to MH's after each CSHS clinic. CSHS will continue to rewrite its clinic manual, and post revised sections on the CSHS website for staff.

Population Based Services
Analyses of LA NS-CSHCN05/06 data indicates increased receipt of CC in LA's Medicaid population but also increased unmet need for CC. Therefore, CSHS will continue to advocate for the DSS-DHH data integration project to create a master patient data base to assist with CC. CSHS will improve coordination between public health programs using its new stakeholder group. Results of the 2010 Needs Assessment Physician Survey will be used to improve MH capacity by addressing identified needs (such as lack of MD knowledge of public health and family support programs) through CC/MH training materials, La AAP and LAFP Newsletter articles, and annual distribution of region specific resource guides to all pediatric providers. Annually updated resource guides will be placed on the CSHS website. CC in MHs will be expanded to include up to four new teaching practices, including two family practice (Bogalusa and Lafayette) and two Tulane pediatric clinics. Clinics that receive a care coordinator will receive a monetary incentive ($20,000) to designate a CC within the practice, making CC sustainable when the contract ends. Participating practices must document progress with MHI's, and will be encouraged to apply for NCQA certification.

Infrastructure Building Services
CSHS will continue to work with administration and the AAP to ensure that the needs of CSHCN

are considered in LA's health care reform, such as linking Medicaid reimbursement to meeting NCQA or other MH criteria and ensuring that CC is reimbursed adequately. The CSHS Director and the statewide CC supervisor will continue to be active on the Advisory Board for the LHCQF MH committee. CSHS will expand CC in both CSHS clinics and pediatric offices to increase access to CC and transition services and to enable MHs to provide these services. CSHS will ensure all LSU and Tulane pediatric and LSU family practice residents receive training in MH and community resources.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	55	55	57	70	70
Annual Indicator	51.9	51.9	65.5	65.5	65.5
Numerator					
Denominator					
Data Source				National Survey of CSHCN	National Survey of CSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	70	70	75	75	75

Notes - 2009
The data reported in 2008 are pre-populated with the data from 2007 for this performance measure.

Notes - 2008
The data reported in 2008 are pre-populated with the data from 2007 for this performance measure.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

a. Last Year's Accomplishments
Direct Services
CSHS staff in all nine regions screened for insurance coverage for all CYSHCN as part of the nursing assessment and transition services. CSHS staff worked with families to determine eligibility for insurance coverage. 92.6 % of CSHS clients had Medicaid, 0.3% of CSHS clients had Medicare, 3.9% of CSHS clients had private insurance and 3.2 % of CSHS clients were covered by CSHS as the payer of last resort.

Enabling Services

PLs and social service staff were available to answer questions and assist families with applying for appropriate insurance/Medicaid coverage. Families were informed and counseled on insurance/Medicaid options, including private insurance, various Medicaid plans such as Supplemental Security Income (SSI) Disability, LaChip Affordable Plan, Medicaid Purchase Plan, Family Opportunity Act and programs such as Children's Healthcare Assistance Plan (CHAP) at Children's Hospital in New Orleans which assists families with limited resources to obtain services at Children's Hospital. Medicaid mail-in applications were provided in CSHS clinic waiting areas and in several regions a Medicaid representative presented CSHS staff with in-services on Medicaid options and decreasing denial rates.

Population Based Services
PLs provided CSHS brochures, health insurance informational brochures, and other resource information on insurance options to families and CYSHCN at health fairs and other community outreach events. CSHS partnered with private and public agencies to assure adequate insurance coverage for CYSHCN. Among CSHS-supported clinics, 88.8% patients had Medicaid, 9.5% had Private Insurance, 1.6% was uninsured, and 0.1% was unknown.

Infrastructure Building Services
The CSHS website was updated as needed with insurance resource information for families. CSHS participated on the healthcare reform CSHCN workgroup to reorganize Medicaid and worked with the American Academy of Pediatrics (AAP) towards increasing the number of children linked to Medicaid primary care providers (PCPs). CSHS administrative staff worked with the Medicaid contact person to assist with SSI Disability and Medicaid Purchase Plan applications to reduce denial rates. CSHS staff worked with Tulane billing department to continue accurate billing for Cystic Fibrosis clients. CSHS worked with all providers to expedite paperwork and ensure sufficient and continuous health care coverage for clients.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Collaborate with Medicaid to assure coverage for CYSHCN.			X	X
2. Screen CYSHCN for health care coverage annually.		X		
3. Provide informational materials to families on Medicaid/insurance options.		X		
4. Work directly with CYSHCN to link them to a Medical Home that accepts their insurance.	X			
5. Track and advocate for LA CYSHCN with regards to the Health Care Reform initiative.			X	X
6. Work with AAP to engage pediatricians in Medicaid healthcare reform policies.				X
7. Work to maximize the number of primary care providers for CYSHCN.				X
8.				
9.				
10.				

b. Current Activities
Direct Services
CSHS PLs and social service staff continues to identify families that need assistance with applying for Medicaid/insurance. CSHS staff screen CYSHCN and link them to an appropriate Medical Home (MH) that accepts their particular insurance plan. CSHS staff continues to verify insurance coverage for all patients annually.

Enabling Services

CSHS staff continues to assist families with completing forms and answering questioning about Medicaid/insurance options. Medicaid mail-in applications continue to be available in all CSHS clinic waiting areas and from CSHS staff. Families of CYSHCN that are 14 years and above are screened for health care coverage and linked to Medicaid/insurance programs during the care coordination/transition program for all 9 regions.

Population Based Services
PLs disseminate information on Medicaid/insurance options for families of CYSHCN at health fairs and other community outreach events. CSHS staff continues to communicate with Medicaid representatives to ensure coverage of CYSHCN. The CSHS website is updated regularly with insurance resource information.

Infrastructure Building Services
CSHS participates on the healthcare reform CSHCN workgroup to ensure that new Medicaid reimbursement policies adequately cover the needs of CSHCN and are linked to providers meeting MH criteria. CSHS works with AAP to ensure policies developed will be accepted by pediatricians to maximize the number of PCPs for CSHCN.

c. Plan for the Coming Year
Objective: 70% of families of CSHCN ages 0-18 will report that they have public or private insurance that is adequate to meet their needs. (CSHCN survey 2010)

Direct Services
CSHS PLs and social service staff will assist patients & families with insurance plans, forms and direct them to appropriate resources. CSHS will pay insurance co-pays for clinic patients according to CSHS policy. PLs will link CSHS patients and families to the advocacy center to teach families self-advocacy skills for negotiating insurance claims/issues.

Enabling Services
PLs will provide CSHCN families with self-advocacy skills and health insurance information. CSHS administrative staff will develop an insurance pamphlet for families focusing on how to deal with your insurance company. CSHS will continue to provide mail-in Medicaid applications in all CSHS clinics as well as resource information on other insurance coverage sources.

Population Based Services
Parent liaisons will provide health insurance information during health fairs and community outreach events. The CSHS website will be updated with current insurance resource information.

Infrastructure Building Services
The CSHS Director will engage in meetings with Medicaid to increase Medicaid reimbursement for Care Coordination services. CSHS will continue to collaborate with American Academy of Pediatrics to ensure physician input in Medicaid policy development. CSHS will continue to work to maximize the number of children linked to Medicaid-participating primary care physicians.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	70	70	75	90	90
Annual Indicator	68.8	89.3	89.3	89.3	89.3

Numerator					
Denominator					
Data Source				National Survey of CSHCN	National Survey of CSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	90	90	92	92	92

Notes - 2009
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

Notes - 2008
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

a. Last Year's Accomplishments
Direct and Enabling Services
CSHS piloted its new CC program focusing on transition in a second CSHS region. The program was simplified to accommodate CSHS staff shortages. CSHS staff, including Parent Liaisons (PLs) across the state provided direct consultation to families to facilitate linkage to community-based resources. The CSHS Statewide Parent Consultant and Parent Training Coordinator (PCs) conducted quarterly trainings to all PLs on developing skills to enable families of CYSHCN to be linked to appropriate community-based resources. CSHS provided direct medical services to 4,585 CYSHCN in 9 regional clinics where such services were otherwise not accessible.

Population Based Services
PLs participated in family information fairs and provided educational workshops for families on community-based resources. CSHS developed regional resource guides (RRGs) for private pediatric and family practices that serve CYSHCN, to assist in care coordination (CC) activities. CSHS posted its application on the CSHS website for families to complete and mail or fax to their regional CSHS office. Staff in CSHS Central Office responded to website inquires received from families about available services and resources for CYSHCN. The Louisiana Birth Defects Monitoring Network (LBDMN) Family Resource Guide was posted to the CSHS website. The Hearing Speech and Vision (HSV) Program provided CC to families of infants identified through Universal Newborn Hearing Screening and Intervention (UNHSI).

Infrastructure Building Services
CSHS hired a Statewide Care Coordinator to serve as a consultant to private physician practices that serve CYSHCN to facilitate CC and promote the Medical Home (MH) concept. Priority is given to practices that are teaching practices. CSHS hired a care coordinator for the Metro New

Orleans (Region 1) area to work with two private practices to orient residents to medical home concepts and community resources for CYSHCN.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide funding for CSHS staff and Parent Liaisons in all CSHS offices.	X	X		
2. Update regional resource manuals.	X	X	X	
3. Provide workshops and educational programs through PLs to families with CYSHCN.	X	X	X	
4. Collaborate with community agencies and providers to facilitate access of services.		X	X	X
5. Expand Care Coordination.	X	X	X	X
6. Continue to update and enhance CSHS program website.		X	X	
7. Collaborate with state agencies to integrate data.		X	X	X
8. Provide educational information to identified families of CYSHCN.		X	X	
9. Update and distribute Regional Resource Guides.	X	X	X	
10.				

b. Current Activities

Direct and Enabling Services

PLs maintain ongoing review of support services and update regional resource manuals regularly. Clinical protocol with CSHS staff continues to facilitate linkages. The PCs provide quarterly trainings to all PLs. The CC project continues in two CSHS pilot regions. Expansion was delayed to simplify the system to accommodate staff shortages.

Population Based Services

CSHS Care Coordinators in private physician practices work with families of CYSHCN to provide CC services which includes, referrals to community based resources, parent education, and parent counseling. CSHS developed RRGs and distributed them to all 9 regional CSHS clinics and to private physician practices that provide services to CYSHCN. CSHS posts the quarterly newsletter, Family Matters to its website. HSV continues to follow-up infants identified through UNHSI.

Infrastructure Building Services

CSHS continues to employ PCs to facilitate support and training programs for PLs. CSHS organized a stakeholder group consisting of state programs and 2 non-governmental organizations to enhance knowledge and collaboration between programs and to address areas where there are communication/information challenges. CSHS continues to participate in the DSS-DHH Data Integration Project. The Statewide Care Coordinator works closely with private physician practices to model and facilitate the MH concept.

c. Plan for the Coming Year

Objective: 90% of families of children with special health care needs age 0 to 18 will report that community-based service systems are organized so they can use them easily. (CSHCN Survey)

Direct Services

PLs will continue to provide direct consultation to families/patients on community based resources in all 9 CSHS clinics. The Care Coordination project will expand to 2 additional regions of the state.

Enabling Services
CSHS staff will develop a roster of primary care physician (PCP) practices to receive RRGs. CSHS staff will disseminate RRGs to PCP practices and maintain annual updates. CSHS will partner with other state programs and non-governmental organizations to increase community-based resource knowledge among frontline staff through information workshops. PCs will continue to train all PLs on effective means to link families to community resources.

Population Based Services
CSHS staff will develop a roster of Federally Qualified Health Centers (FQHCs) and School Based Health Centers (SBHCs) to receive CSHS brochures, RRGs and Families Helping Families (FHF) brochures. CSHS staff will disseminate CSHS brochures, FHF brochures, & RRGs to SBHCs and FQHCs. LBDMN staff will advertise the Family Resource Guide in birthing hospitals. LBDMN staff will conduct a pilot test of the Family Resource Guide and maintain annual updates. CSHS will continue to post the quarterly newsletter, Family Matters, to the program website. The Statewide Care Coordinator will continue to serve as a consultant to private physician practices to facilitate the Medical Home concept. CSHS Care Coordinators in private physician practices will continue to work with families to link them to community resources.

Infrastructure Building Services
CSHS will continue to employ PCs to facilitate training programs for families and PLs statewide. CSHS will facilitate referrals between other state programs by partnering with non-governmental organizations to increase community-based resource knowledge among statewide stakeholder frontline staff through information workshops. CSHS will continue to participate in the DSS-DHH Data Integration Project to create a master patient data base that will facilitate CC by enabling multiple program eligibility determination.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	6	6	10	44	44
Annual Indicator	5.8	5.8	40.9	40.9	40.9
Numerator					
Denominator					
Data Source				National Survey of CSHCN	National Survey of CSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	44	44	44	44	46

Notes - 2009
The data reported in 2008 are pre-populated with the data from 2007 for this performance measure.

Notes - 2008
The data reported in 2008 are pre-populated with the data from 2007 for this performance measure.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

a. Last Year's Accomplishments
The 2005/2006 CSHCN Survey showed 40.9% of YSHCN in Louisiana received services necessary to make transition to all aspects of life.

Direct and Enabling Services
CSHS staff completed transition screenings in direct clinical settings in all 9 regions and provided service coordination for identified needs for YSHCN. Two regions (New Orleans area and Central Louisiana area) provided more intensive care coordination (CC) for youth in transition.

Population Based Services
CSHS provided funding for care coordinators in 3 private primary care practices. In 2 of the practices youth were screened for transition needs by the private practice staff. Youth with a higher level of need were provided care coordination services by the CSHS funded care coordinator. The CSHS website was updated to reflect changes in contact information for state agencies that serve CYSHCN. The regional PLs provided transition information and guidance at local health fairs and in conjunction with other local parent training and community events. Transition articles were published in the quarterly CSHS Newsletter, Family Matters. CSHS worked closely with a liaison from the Medicaid Office to facilitate applications for YSHCN to other appropriate Medicaid programs especially for youth over age 19 who became ineligible for LaChip. Staff worked to inform families about the Medicaid Purchase Plan and were very successful in assisting numerous young adults to access these benefits while maintaining employment. CSHS also worked to inform staff in the two certified cystic fibrosis centers about how they could assist young adults in their practices to access health insurance and developed a system where they could contact CSHS to learn more about linkages to transition resources. CSHS regional staff also developed partnerships with regional Medicaid staff to assist YSHCN/families in the Medicaid application process. This facilitated better collaboration between agencies in working to help youth access appropriate Medicaid programs.

Infrastructure Building Services
CSHS collaborated with other agencies in the Department of Health and Hospitals (DHH) and the Department of Social Services (DSS) to begin a study on data integration to assist agencies to identify and link YSHCN to eligible programs within these departments. The statewide parent liaison (PL) and parent training coordinator facilitated transition trainings at quarterly PL staff trainings.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Screen adolescents and young adults in CSHS clinics in 7 regions for transition needs and provide information as requested.	X			

2. Provide transition care coordination in CSHS clinics in 2 regions of the state.	X			
3. Provide transition care coordination in 2 private primary care practices.	X			
4. Update CSHS website on resources/activities related to transition.			X	
5. Provide transition information at health fairs and other community education programs.			X	
6. Provide quarterly transition training to CSHS & FHF transition parent liaison staff.			X	
7. Collaborate with other state agencies to coordinate transition services.				X
8. Collaborate with other DHH agencies and DSS on data integration project.				X
9.				
10.				

b. Current Activities

Direct and Enabling Services

CSHS staff screen YSHCN in CSHS clinics statewide on transition needs and provide services as identified. The more intensive CC project continues in 2 regions, but did not expand to a 3rd region due to staff shortages.

Population Based Services

Transition screening is provided in 2 academic primary pediatric care practices. The 5 year CC contract in the Bogalusa practice was completed. A CC was added to a TigerCare clinic in Kenner which serves a predominately Hispanic population. The CC in this practice is fluent in Spanish. The staff has been able to provide families with information and linkages to needed resources, particularly with educational concerns. The CSHS website is updated as new transition information is identified. PLs provide transition information at local programs. Transition related articles are included in the quarterly Family Matters newsletter, as well as regional and statewide summer camp information for CYSHCN. CSHS works closely with the designated Medicaid liaison to strength the partnership in serving youth in both programs.

Infrastructure Building Services

CSHS is participating in multi-agency collaborations targeted at comprehensive, coordinated transition services for YSHCN. Collaboration continues with DHH and DSS in the development of the data integration project. The CSHS Parent Consultants conduct quarterly trainings for regional PLs, which will emphasize issues related to transition and the CC process.

c. Plan for the Coming Year

Objective: 44% of YSHCN report receiving services necessary to make transitions to all aspects of life, including adult health care, work, and independence.

Direct

CSHS staff will expand the more intensive CC process to 2 additional regions and continue screening and providing service coordination for adolescents over age 14 for transition needs in the other 5 regions. PLs will work with YSHCN in direct CSHS clinics statewide on transition needs and provide services as needed.

Enabling

CSHS will expand funding for CC in 4 additional private primary care practices, all of which will include transition screening and services. Regional resource guides and transition brochure will

be given to each office.

Population Based services
Regional PLs will educate and support families/YSHCN on transition through participation in health fairs and trainings in all nine regions. Regional resource guides, CSHS brochures and Families Helping Families brochures will be sent to Federally Qualified Health Centers and school based health clinics. The resource guides will also be given to other providers serving YSHCN, as requested. The transition section of the CSHS website will be updated, including periodic updates to the regional resource guides.

Infrastructure Building Services
CSHS will participate in multi-agency collaborations targeted at comprehensive, coordinated transition services for YSHCN. Collaboration will continue with DHH and DSS in the development of the data integration project. CSHS will submit transition articles to the state AAP and LAFP (family practice) newsletters. PLs will be provided quarterly trainings on transition topics, such as new or expanded services.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	74	80	84	82	82
Annual Indicator	74.9	72.3	77	81.9	81.9
Numerator					
Denominator					
Data Source				The National Immunization Survey (NIS)	The National Immunization Survey (NIS)
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	85	87	90	90	90

Notes - 2009
2009 data is provisional and based upon 2008 data.

Notes - 2008
2008 data is final.
The National Immunization Survey (NIS) is sponsored by the National Immunization Program (NIP) and conducted jointly by NIP and the National Center for Health Statistics (NCHS), Centers for Disease Control and Prevention. The survey is a list-assisted random-digit-dialing telephone survey followed by a mailed survey to children's immunization providers. Estimates of vaccine coverage are produced for the nation and for each of 78 Immunization Action Plan (IAP) areas, consisting of the 50 states, the District of Columbia, and 27 large urban areas. Final 2008 data

from the NIS survey for Louisiana indicates 81.9 + 4.6% of children within the ages of 19-35 months are at the appropriate immunization level for age for the vaccine series 4:3:1:3:3:1 which now includes 1 dose of Varicella vaccine in the series.

Notes - 2007
The National Immunization Survey (NIS) is sponsored by the National Immunization Program (NIP) and conducted jointly by NIP and the National Center for Health Statistics (NCHS), Centers for Disease Control and Prevention. The survey is a list-assisted random-digit-dialing telephone survey followed by a mailed survey to children's immunization providers. Estimates of vaccine coverage are produced for the nation and for each of 78 Immunization Action Plan (IAP) areas, consisting of the 50 states, the District of Columbia, and 27 large urban areas. Final 2007 data from the NIS survey for Louisiana indicates 77 + 6.1% of children within the ages of 19-35 months are at the appropriate immunization level for age for the vaccine series 4:3:1:3:3:1 which now includes 1 dose of Varicella vaccine in the series.

a. Last Year's Accomplishments
Direct and Population Based Services
The Louisiana Office of Public Health (OPH) Immunization Program's continual challenge to maintain high immunization levels remains through collaborative efforts that demand local involvement and commitment of other programs, private Vaccines for Children providers (VFC) and school-based agencies. To this end, the Program has directed many of its efforts to build community coalitions, educate medical providers about the importance of immunizations; implement, maintain, and enhance the Louisiana LINKS Immunization Registry; and raise public awareness through the Shots For Tots campaign to encourage parents to get their children two years old and younger vaccinated on an age-appropriate schedule. In addition to these efforts, changes in the delivery of newly developed combination vaccines aim to offer broader immunization coverage of multiple vaccine-preventable diseases and enhance disease prevention efforts.

Louisiana's ranking of immunization coverage rate for Year 2008 as indicated by the annual CDC National Immunization Survey remarkably improved in the national standing from 28th to 2nd among states with an increase in immunization coverage rate from 77% to 81.9% when compared to Year 2007. This exceptional improvement from previous years is a remarkable achievement in addition to exceeding the 2008 national level of 76%. Despite this increase, the program continues to strive toward achieving the primary goal of 90% immunization coverage rate among children through age two established by the Healthy People 2020.

The 16th annual Shots for Tots (SFT) Conference was held in November 2008. The conference provided information to all health care providers in the delivery of comprehensive immunization services for all age groups, explored innovative strategies for improving immunization coverage, and provided the latest scientific information on newly developed vaccines. In addition, National Infant Immunization Week (NIIW) was conducted between April 25th and May 1st , 2009. All walk-ins and scheduled appointments for immunizations were available statewide at all public health units for which the usual administrative fees were waived.

The VFC-Assessment, Feedback, Incentives and Exchange program conducts ongoing quality assessment practices and provides feedback to the VFC providers which contributes to enhancing the Immunization Program's ability to assess and improve immunization delivery practices at the provider's level and assure that VFC eligible children are receiving quality services.

Infrastructure Building Services
The Louisiana OPH Immunization Program continues to collaborate with the Medicaid Program regarding the incentive pay-for-performance immunization initiative. This initiative involves participation with the LINKS registry by VFC providers with the goal of achieving age-appropriate immunizations as per American Committee of Immunization Practices (ACIP) schedule. During

2007 - 2008, 317 providers received incentive payment where 57% of these providers had an average increase of 14.3% in the percent of up-to-date 24 month old vaccine recipients; in comparison, 2008 - 2009, 328 providers received incentive payments of which 51% had an increase in the percent of up-to-date 24 month old vaccine recipients with an average increase of 12.8%.

Reminder/recall immunization drills were conducted for age groups 0 -- 6 years of age and 11-13 years of age where postcard reminder notices were mailed utilizing the LINKS system data.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Supply vaccines to enrolled providers through the Vaccines for Children (VFC) program.			X	
2. Expand VFC provider enrollment.			X	X
3. Expand on-site VFC/AFIX (Assessment Feedback Information Exchange) active provider sites.				X
4. Expand the Louisiana Immunization Network for Kids Statewide (LINKS) by integrating data systems and partnering with other providers to enhance vaccination coverage.				X
5. Enhance efforts to provide immunizations in public health units monitored by CASA state surveillance reviews.	X		X	X
6. Coordinate with Medicaid Program with pay-for-performance incentives to improve immunization practices.		X		X
7. Annual Shots for Tots Conference.				X
8. Conduct immunization reminder/recall notifications quarterly.		X		
9. Annual National Infant Immunization Week campaign.		X		
10.				

b. Current Activities

Despite staff shortages, VFC-AFIX visits are continuing to increase with a focus on face to face feedback educational sessions to incorporate best practices of the Immunization Program targeting immunization rates, vaccine management/ assessment, use of the LINKS registry, and provision of educational information to VFC providers. The goal of the feedback educational sessions is VFC compliance and ultimately the continual increase in immunization rates.

The 17th Annual Shots for Tots Conference held October 2009 provided information to all health care providers in the delivery of comprehensive immunization services for all age groups, explored innovative strategies for improving immunization coverage, and provided the latest scientific information on newly developed vaccines. There were 302 in attendance and awarded 196 CE's for this event.

National Infant Immunization Week (NIIW) was held April 2010 to increase immunization awareness throughout the state via health care fairs/festivals in small, thinly populated areas with poor access to medical care, distribution of information about vaccines to raise awareness about the importance of infant immunizations, mass reminder recall mailings to past due children statewide, and mass postings of 100 banners with the immunization schedule, web address and toll-free number for public locations across Louisiana. Despite budgetary constraints, the Medicaid pay-for-performance (P4P) initiative will continue.

c. Plan for the Coming Year

Objective: To improve the current statewide vaccination coverage rate by 3% among children 19 - - 35 months of age for year 2010-2011 with completion of the 4:3:1:3:3:1 series to achieve the 90% Healthy People Performance Objective.

Activity Objectives: For each 2 year old child, ensure age-appropriate immunizations received and enrollment in LINKS by conducting provider practice site audits, educating communities about importance of vaccination by coordinating with local health departments, private providers and other community based organizations to improve immunization rates.

Ongoing projects to enhance the ability to measure and track UTD coverage via the Immunization Information Systems will continue including a) collaboration with Louisiana Medicaid for the Pay-for-Performance initiative as Medicaid provides supplemental payments to providers and recognized as a Medicaid Promising Practice; b) ongoing and continual feasibility study with METRON, the same system used by physicians for billing purposes, to collect reimbursable revenues from third-party insurance billing for services rendered at public health immunization clinics; c) conducting quarterly reminder/recall notifications to inform parents to update their children's immunizations utilizing the LINKS database; and d) development and piloting a child-care module via LINKS to capture child-care aggregate data for UTD and age-appropriate vaccination coverage.

Outreach activities for the coming year include the annual National Infant Immunization Week to be held in April 2011 to offer continual support for local and state community coalition initiatives and activities as well as increase immunization awareness throughout the state in collaboration with internal and external partners.

The annual Shots for Tots (SFT) Conference plans are underway for October 2010. With support of private partnerships, 50,000 plastic immunization record holders were purchased and placed in birthing packets in addition to 50,000 note pads with the immunization schedule watermarked to be passed out at health fairs. The SFT Coalition is initiating project plans to educate child care workers and offer CE's and additional resources to improve immunization coverage to be implemented in 2010-2011 in conjunction with hospital partners. The Coalition is also working on maintenance of the coalition and board of directors as well as recruiting additional community partners.

VFC-AFIX visits will continue with a focus on face to face feedback educational sessions to strategically achieve an increase or improvement in: a) immunization rates, b) vaccine management and assessments, c) increase participation in the LINKS registry, and d) provision of educational information to VFC providers. The emphasis of the feedback sessions is aimed at VFC compliance and assuring the children of Louisiana receives quality services through education and support of VFC providers.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	30	29	25	25	24.5
Annual Indicator	26.6	30.0	30.9	29.4	29.4
Numerator	2670	2824	2892	2772	2772
Denominator	100211	94142	93471	94353	94353
Data Source				Louisiana Vital Records and Statistics	Louisiana Vital Records and Statistics

Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	24	23	23	22	22

Notes - 2009
2009 data is provisional and based upon the 2008 data.

Notes - 2008
Data for 2008 is provisional.

Notes - 2007
Data for 2007 is final.

a. Last Year's Accomplishments
Direct Services
In 2008, the total number of live births for female teenagers aged 15 through 17 was 2,585 with a total number of women all ages was 65,091. The 2008 rate of birth (per 1,000) for female teenagers aged 15 through 17 years was 28.8 versus 30.9 in 2007 and 30.0 in 2006. The Louisiana Family Planning Program (FPP) rendered services to nearly 66,000 patients through its 69 parish health units and eight contract sites in 2009. In the same year, 5,714 female teenagers aged 15 through 17 utilized family planning services.

Enabling Services
Adolescent clients are high priority in Family Planning (FP) clinics throughout the state of Louisiana. Education and counseling sessions are tailored to adolescent clients. The FPP partners with the School Based Health Centers (SBHCs), which refers adolescents to FP clinics for services that are not provided in the SBHCs. This agreement assists adolescents in receiving health services such as Pap test, breast exams, pregnancy testing, testing for Sexually Transmitted Diseases and HIV, counseling and education. In addition, high school students provide feedback on FP service delivery.

A FPP contract site, that provides health services to adolescents in the New Orleans Metropolitan area, have enhanced and expanded male family planning services. The purpose of this new contract is to educate male youth between the ages 13-24 about contraceptive methods, preconception counseling, fatherhood counseling, and STD/HIV prevention and treatment. The contract site has traditionally attracted youth at high risk for reproductive health problems, including the homeless.

Infrastructure Building Services
The FPP State Health Education and Outreach Plan was developed and implemented in all FPP service sites. The plan helped structure outreach activities to better serve adolescents in the community and direct services where needed most. In January 2009, the FPP, with consultation from the Center for Health Training, provided a Women's Health training to FP staff on Screening for and Preventing Intimate Partner Violence. In May 2009, a face-to-face workshop on Increasing Family Involvement with Teen Clients was provided to FP staff. To identify barriers to family planning services for adolescent clients, Mystery Caller Assessments were conducted in all FPP service sites.

The FPP educated adolescents about the importance of preconception care. Adolescents seen in FPP clinics received education regarding the importance of folic acid tablets before and during pregnancy. The project was initiated in July 2008 and was recently evaluated July 2009. The purpose of the evaluation was to determine the utilization of folic acid supplements by female clients. The FPP has developed a plan to increase distribution of folic acid tablets, remove existing barriers, and improve education amongst female clients who are of reproductive age.

Population Based Services
The FPP purchased and distributed language appropriate and age-specific educational materials that specifically addressed adolescents and teen pregnancy prevention. Topics included: Abstinence, Self-esteem, HIV/AIDS and STDs, Sexual Intimidation, Dating Violence, Building Relationships, Deciding about Sex, Parenthood, and Birth Control Methods. Outreach is conducted throughout the state of Louisiana, specifically at high schools, beauty salons, and juvenile court groups.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide comprehensive reproductive health care services to adolescents.	X			
2. Present and distribute education materials to teens and professionals.		X	X	
3. Provide technical assistance on teen pregnancy prevention mass media campaigns.			X	X
4. Provide training manual to clinic nurses for education on adolescent reproductive health issues.				X
5. Conduct Mystery Caller Study to assess adolescent need.				X
6. Promote clinical trainings to create a teen-friendly environment and increase teen utilization.				X
7.				
8.				
9.				
10.				

b. Current Activities
Direct and Enabling Services
The FPP prioritize adolescents for receiving clinical services. Age appropriate education and counseling is provided and parental involvement is encouraged. The FPP maintain relationships and networks with the adolescent population; educate adolescents about FP services; and continually invite adolescents to participate with FPP State Advisory Board activities.

The FPP adolescent contract site provides young males health information, education and clinical services to delay sexual debut, practice effective sexual hygiene, responsible STD prevention, and assist partners with STD protection. Services are provided during traditional and non-traditional hours, with evening and/or Saturday clinics.

Infrastructure Building Services
Efforts to increase knowledge of folic acid and increase the total number of females receiving folic acid in FP clinics are now underway. Throughout the months of September through February 2009, the FPP Medical Director and Nurse Practitioner presented statewide face-to-face workshops on HPV 101 and Gynecological Issues to FP staff. Future training activities and events are currently being developed based on the training need assessments and quality

assurance reports. Mystery Caller Assessments were conducted late 2009 and early 2010.

Population Based Services
The FPP coordinate and facilitate the issuance of educational materials to adolescents. The FPP communicate adolescents' concerns to the FPP advisory board.

c. Plan for the Coming Year
Objective: Decrease birth rate to 25 (per 1000) for teenagers aged 15 through 17 years.

Direct and Enabling Services
The FPP is committed to enhancing services to attract adolescent clients by developing and strengthening community-based organizations working with adolescents. The FPP will continue to develop and maintain collaborative efforts with community-based organizations and SBHCs to specifically target the adolescent community. A non-profit organization working with the Center for Health Training will incorporate results obtained from focus groups conducted with Louisiana FPP adolescent clients and staff. Health education materials will be developed for persons who have a difficult time reading and understanding instructions for taking medications, specifically birth control.

The FPP will continue to enhance and expand male family planning services. The adolescent contract site will continue to dedicate male only services on Tuesday evenings. The contract site will provide educational outreach that will include focus groups, special sports activities, and expansion of current Peer-led Street Outreach Program to tailor educational sessions to young males about health related topics. Individual counseling will continue to be provided to young men to increase knowledge about individual risk, proper usage of birth control methods, risk and benefits, and partner acceptability.

Infrastructure Building Services
The Health Education and Outreach Plan will be revised to include the results obtained from focus groups conducted with adolescents. The FPP will continue to educate adolescents about the importance of preconception care and folic acid. The FPP upcoming trainings include Male Reproductive Services and Contraceptive Choices. Mystery Caller Assessments will be conducted to identify barriers to services for family planning adolescent clients.

Population Based Services
Educational materials will continue to be updated and reviewed by a review committee to ensure the materials are appropriate for the community served. Adolescents will continue to be recruited as FPP State Advisory Board members.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	20	20	20	23	40
Annual Indicator	18.0	18.0	18.0	33.2	33.2
Numerator	157	157	157	16223	16223
Denominator	871	871	871	48894	48894
Data Source				Basic Screening	Basic Screening

				Survey	Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	40	40	40	40	40

Notes - 2009
The Oral health Program has completed the Basic Screening Survey and the final results are available to share. According to the survey, 41.9% of third grade children had untreated dental caries, 65.7% had dental caries experience, only 33.2% had dental sealants on at least one of the permanent molar teeth, and 42.7% had to be referred to dentists for treatment. The total number of children screened were 2642(Denominator) and out of that only 899 (Numerator) had dental sealants. To calculate the percent of 3rd graders with dental sealants, the weighted numbers have been used for the numerator and the denominator which represent the 3rd grade population in the state. The value of the weighted numerator is 16,223 and the value of the denominator is 48,894.

Notes - 2008
The real values for the numerator (N) and denominator (D) are 899 and 2642 and the weighted values of N and D have been used to calculate annual indicator. The State Oral Health Program has preliminary results of the Basic Screening Survey. According to these results, 33.2% of Louisiana 3rd grade children have dental sealants on at least one of their permanent molar teeth. There are 41.9% percent of children with untreated caries and 65.7% of children with caries experience.

Notes - 2007
The State Oral Health Program has begun collecting sealant prevalence data on 3rd graders statewide, every 5 years. This data is used to tabulate the sealant prevalence rate for FY2006 because the Oral Health Program is confident that this data more accurately reflects the sealant status of this population than the data previously collected more than 5 years ago.

a. Last Year's Accomplishments
The Oral Health Program (OHP) completed the Basic Screening Survey (BSS) to determine the oral health of third grade children in Louisiana. The 2009 BSS was the first representative sample for Louisiana and the data gathered will be used to direct the school-based dental sealant program to areas with the most need. The survey included an assessment of the children's oral health status and determination of the presence of dental sealants on permanent 1st molars. Seventy-five schools were randomly selected to be included in a representative sample of the 3rd grade student population. The survey included an assessment of the children's oral health status and determination of the presence of dental sealants on permanent 1st molars. A total of 2642 children were screened which when weighted accounted for 48,894(Denominator), 3rd grade children. Among the children screened, only 899 had dental sealants which when weighted accounted for 16,223 (Numerator), 3rd graders. The weighted numbers of the children were used to calculate the percentage of children with dental sealants. There were 33.2 percent of 3rd grade children who had a sealant on at least one permanent molar tooth.

Direct Services
The MCH Oral Health Program continued to expand the dental sealant program for 1st, 2nd, and 6th grade children in an effort to increase the number of children with dental sealants. Twelve

parishes participated in the program last year, including Allen, Avoyelles, Caddo, Catahoula, Concordia, East Baton Rouge, East Feliciana, Lafayette, LaSalle, Madison, Rapides and Orleans. The number of schools served increased from 45 to 57. The number of children screened increased from 2,676 to 2,852 with the number of sealants place increasing from 4,967 to 6,302.

Enabling Services
MCH Oral Health Program staff continued to partner with Medicaid outreach efforts to ensure that eligible pregnant women received needed dental services. The Oral Health Program staff attended the Louisiana Dental Association (LDA) Annual Meeting to promote provider enrollment in the dental Medicaid program. Program material was disseminated and the oral health program staff offered information to update providers on administrative issues regarding the dental services program for pregnant women.

Population Based Services
The Fluoridation Program continued to address efforts to increase the proportion of the population benefiting from optimally fluoridated water. In response to the fluoridation mandate act passed in 2008, the Oral Health Program and the LDA formed the Healthy Smiles Coalition. This group of community water fluoridation advocates provided education to the public, local governments, and the media on the health benefits of optimally fluoridated water in four communities. The group has met on a regular basis to strategically work with identified communities to initiate fluoridation. The program continues to work with the town of Walker to initiate fluoridation.

Infrastructure Services
In the second year of funding of the CDC State-Based Oral Disease Prevention Cooperative Agreement, the Oral Health Program added two fulltime staff, a Fluoridation Engineer and a Dental Sealant Program Coordinator/Health Education Coordinator. The program also realigned the duties of another staff to be the program's Epidemiologist/Evaluator.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Expansion of the dental sealant program into three new parishes.	X		X	
2. Development sustainability plan for a dental sealant program model for statewide application in Louisiana.	X			X
3. Partnered with LSU School of Dentistry, Louisiana Dental Association, and other partners to provide dental sealants on Give Kids a Smile Day.			X	X
4. Sealant program participants receive oral hygiene instruction and oral health aids to promote improvement of oral health.	X	X		
5. Plan to determine the retention rates of sealants in program in a sample of participants.	X		X	
6. Identifying funding sources for the expansion of the sealant program.			X	X
7.				
8.				
9.				
10.				

b. Current Activities
Direct Services
The Oral Health Program (OHP) collaborates community clinics and private practice dental providers to reach underserved area of the state in the school-based dental sealant program. The

OHP uses data from the 2009 Basic Screening Survey to identify areas with the greatest need.

Enabling Services
OPH partners with Medicaid to ensure that eligible pregnant women and children receive dental services and participates in education and recruitment of dental and medical professionals. The staff attends meetings with non-dental health professionals, presenting information on dental screenings, evidenced --based practices, and anticipatory guidance on oral health for infants, children, and pregnant women.

Population Based Services
The OHP and stakeholders works to initiate fluoridation in communities, educates city governments, and provides training to water operators. The OHP provides funding and technical assistance for community water fluoridation projects to bring existing systems into compliance with the rules of operation and with new systems to initiate fluoridation. The OHP promulgated new rules for safe operation of fluoridating water systems to bring Louisiana in compliance with the CDC fluoridation recommendations.

Infrastructure Services
The OHP is developing a burden of oral disease in Louisiana. The OPH is organizing a state-wide Oral Health Coalition; the Coalition members are working on a draft of an Oral Health State Plan and a Policy Action Plan.

c. Plan for the Coming Year
Objective; Increase to 40% the share of third grade children who have received protective sealants on at least one permanent molar tooth.

Direct Services
Through direct service and partnership with community resources, school-based sealant initiatives are planning to serve 15 parishes. The program will work to expand our network of participating partners and providers, linking school in underserved areas with providers.

Enabling Services
The OHP will use the resources of the newly formed Oral Health Coalition to promote the Medicaid covered dental services for pregnant women with periodontal disease to pregnant women, prenatal providers, and dentists.

The program will work toward increasing the number of dental providers treating Medicaid eligible children. MCH will provide continuing education and program information to dental health providers in the state in forums such as dental society meetings and annual state conferences.

Population Based Services
The OHP will work to increase the number of Louisiana residents who receive the protective benefit of community water fluoridation and to increase our community education efforts through local, grass-roots efforts in communities affected by the fluoridation mandate. The program will implement an ongoing training program for water operators to ensure safe and consistent delivery of the optimal levels of the fluoride ion and promote the benefits of community water fluoridation. In the coming year, the OHP has identified one new community to initiate fluoridation and two communities that need financial assistance to upgrade equipment to meet newly revised operational standards. The program in partnership the Fluoridation Advisory Board, the Healthy Smiles Coalition, local chapters of the Dental and Dental Hygiene Associations, and the DHH Regional staff will launch a grass-roots community education campaign in two targeted areas. Eventually the program will expand this campaign, reaching all regions of the state.

Infrastructure Services
The OHP will work with our program stakeholders to promote stability for the continuation of the

Oral Health Coalition and implementation of the Oral Health State Plan. The OHP will continue our efforts to implement Medicaid reimbursement for the application of dental sealants under the direction of the OHP. The OHP and the Policy group of the Oral Health Coalition will work to bring about policy and/or systems changes that will result in increased access to dental services for the MCH population.

Through the additional staffing provided by the CDC Cooperative Agreement and the additional funding from the HRSA Work Force Development Grant, the Oral Health Program should be able to enhance its capacity to develop and expand the School-based Dental Sealant Program and Community Water Fluoridation efforts.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	6.7	6.7	4	4	4
Annual Indicator	5.2	4.8	5.7	5.0	5.0
Numerator	49	43	51	46	46
Denominator	946320	897508	888587	914724	914724
Data Source				Louisiana Vital Records and Statistics	Louisiana Vital Records and Statistics
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	4	4	4	4	4

Notes - 2009
2009 data is provisional and based upon the 2008 data.

Notes - 2008
2008 data is provisional.

Notes - 2007
2007 data is final.

a. Last Year's Accomplishments
Preliminary data shows that in 2008, 46 children aged 0-14 years were killed in motor vehicle crashes (mvc's) at a rate of 5.0 deaths/100,000 children, which is lower than the 2007 final rate of 5.7 death by mvc's /100,000 children and Healthy People 2010's goal of 9.0 deaths by mvc's/100,000 population. Final rates for 2004, 2005, and 2006 are 7.0, 5.1, and 4.8 deaths by mvc's/100,000 children, respectively. Data for 2009 is not yet available for reporting.

Population-Based Services

The MCH Program has worked toward reducing child motor vehicular deaths by continuing to fund the 9 OPH Regional MCH Child Safety Coordinators, who are certified National Child Passenger Safety Certified Technicians (CPST's) and who participated in car seat/child restraint check-up events, in collaboration with the Louisiana Passenger Safety Task Force, Louisiana Highway Safety Commission, first responders (EMT's, firefighters and law enforcement), and other CPST's. In 2009, the MCH Child Safety Coordinators participated in more than 831 child passenger safety events, which reached more than 11,440 people statewide, and 1,026 seats/child restraints were checked at check-up events and fitting stations. In 2008, more than 5,100 people participated statewide in more than 516 local child passenger safety events, and 1,448 seats/child restraints were checked at check-up events and at fitting stations. Also, the MCH Child Safety Coordinators continued to promote/participate in the distribution of infant /child car seats/booster seats to low income and other high risk families.

Infrastructure Building Services
The MCH Child Safety coordinators continued to offer technical assistance and culturally appropriate educational outreach in child safety/injury prevention, including child passenger safety and pedestrian safety, to health providers, educators, childcare providers, faith-based and community leaders, and the general public through seminars, workshops, health fairs, the media (radio and television), printed materials (brochures, newsletters, pamphlets), and presentations. In 2009, more than 49,950 children and adults were reached with culturally appropriate child safety/injury prevention educational information compared to 34,000 people reached in 2008.

MCH continued to manage Louisiana Child Death Review, which includes state and local panels that review unexpected deaths of children under the age of 15 years resulting from motor vehicle crashes and from other unexpected, unintentional injuries, and SIDS. In 2009, the State and Local CDR Panels reviewed at least 142 unexpected infant and child deaths, and the MCH Child Safety Coordinators continued to serve as the local CDRP Coordinators. In 2008, at least 121 unexpected infant and child deaths were reviewed by the State and Local CDRP's.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. MCH Child Safety Coordinators will promote use of child car restraints and participate in car seat check-up events, in collaboration with the Louisiana Passenger Safety Task Force and Louisiana Highway Safety Commission.			X	
2. MCH Child Safety coordinators to distribute car seats and booster seats, if available, to needy children.			X	
3. MCH to provide technical assistance and collaborate with the EMS-C/ Injury Research & Prevention Program on childhood injury and motor vehicle occupant injury prevention program planning/activities and policy development.				X
4. Support the outreach efforts of the nine regional MCH Child Safety Coordinators to provide safety/injury prevention education and resources.				X
5. MCH Child Safety Coordinators will collaborate with epidemiology colleagues to report injury data to implement effective child motor vehicle occupant and other injury prevention interventions.				X
6. Child Death Review Panels will review all unexpected deaths of children under the age of 15 years resulting from motor vehicle crashes and other causes.				X
7.				

8.				
9.				
10.				

b. Current Activities

Population Based Services

The MCH Child Safety Coordinators continued to distribute car/booster seats and participate in car seat restraint check-up events/fitting stations. Several coordinators were trained on inspecting car restraints for children with special healthcare needs. Since October 2009, at least 619 car seats/restraints have been checked compared to 524 in 2008.

Infrastructure Building Services

MCH Child Safety Coordinators continue to offer child safety educational outreach. MCH participates on the EMS-C Advisory Council and assists in providing injury prevention activities for over 1,000 Head Start children on EMS-C Day. Since October 2009, over 18,258 people were reached in over 716 events statewide.

The State and Local Child Death Review Panels (CDRP) have continued to review unexpected deaths of children 14 years and under, including motor vehicle-related deaths. Since October 2009, more than 40 cases have been reviewed.

c. Plan for the Coming Year

Objective: To decrease to 4 per 100,000 children the rate of deaths to children aged 14 years and younger caused by motor vehicle crashes.

Population-Based Services

The MCH Child Safety Coordinators will continue to distribute car seats and booster seats, if available, to children in need and will continue to participate in car seat/child restraint check-up events and fitting stations, in collaboration with Louisiana Passenger Safety Task Force, first responders (EMT's, firefighters and law enforcement), and other CPST's.

Infrastructure Building Services

In order to reach our objective, the MCH program will continue to support the MCH Child Safety Coordinators to provide technical assistance, injury prevention educational outreach, and motor vehicle occupant injury prevention activities, which are community-based and culturally appropriate for the target at-risk populations. The educational materials are also available in Spanish for the growing Hispanic population with limited proficiency of the English language in Louisiana.

Louisiana Child Death Review will continue to review child deaths under 15 years of age resulting from motor vehicle crashes and other injury-related causes; implement/ promote effective injury prevention interventions at the state and local levels, in collaboration with the Injury Research and Prevention Program and Emergency Medical Services for Children (EMS-C); improve investigative case reporting; provide trainings on effective, culturally sensitive/appropriate child death investigations to CDRP members, coroners/medical examiners, and death scene investigators; and submit the State CDRP Report to the Louisiana Legislature, CDRP members, policy makers, program planners, DHH, MCH staff /partners, and the general public.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective		10.4	15.6	15.8	25
Annual Indicator	15.2	15.2	21.9	21.9	20.8
Numerator	9253	9253	66	66	71
Denominator	60873	60873	302	302	342
Data Source				National Immunization Survey (NIS)	National Immunization Survey (NIS)
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	26	27	28	29	30

Notes - 2009
This year's data is provisional and based upon 2006 National Immunization Survey (NIS) data. LaPRAMS 2006 data indicated that 17.02% of mothers breastfed their infants at 6 months of age, however, LaPRAMS has not reached 70% response rate since Hurricane Katrina in 2005 and therefore data is unreliable. Furthermore, infants are between 2 and 6 months at the time of the survey, which may lend bias to the question of breastfeeding at six months.

Notes - 2008
This year's data is provisional and based upon 2005 National Immunization Survey (NIS) data. LaPRAMS 2006 data indicated that 17.02% of mothers breastfed their infants at 6 months of age, however, LaPRAMS has not reached 70% response rate since Hurricane Katrina in 2005 and therefore data is unreliable. Furthermore, infants are between 2 and 6 months at the time of the survey, which may lend bias to the question of breastfeeding at six months.

Notes - 2007
Data is provisional and based upon 2005 NIS data.

a. Last Year's Accomplishments
Louisiana's breastfeeding rates continue to lag behind the Healthy People 2010 goals for breastfeeding. In 2005, 22% of women in Louisiana were breastfeeding at 6 months according to National Immunization Survey (NIS). Although there has an upward trend in breastfeeding rates in Louisiana, NIS provisional data for 2006 indicates a slight decrease, with 20.8% of Louisiana women breastfeeding at 6 months.

Enabling Services
WIC sites continued to create clinic environments that endorse breastfeeding as the preferred method of infant feeding. Sites addressed large disparities seen among the different racial and ethnic groups by utilizing updated and culturally appropriate educational videos, handouts and posters. Structured breastfeeding classes were offered to participants. The breastfeeding peer counseling program continued an on-going effort in all regions except regions 6 and 7, serving 16, 383 participants to support and increase breastfeeding initiation and duration rates. WIC continued to provide manual, electric and personal electric breast pumps to participants as needed.

Population Based
Breastfeeding awareness information and support continued at the community level, including hospitals, faith-based organizations, physicians offices, health care providers and community events. Local businesses were recruited to become breastfeeding friendly employers as a major community breastfeeding projects.

A hospital-based breastfeeding incentive program, entitled The Gift (Guided Infant Feeding Techniques), continued its third year of implementation. The Gift supports and encourages Louisiana birthing facilities to implement evidence-based policies and practices surrounding breastfeeding. Birthing facilities that meet The Gift's "Ten Steps to a Healthy, Breastfed Baby" receive the designation of "Gift Certified." Gift Certification must be re-applied for every 2 years. There are approximately 62 maternity hospitals and 1 birthing center in Louisiana. From October 1, 2008 to September 30, 2009 five birthing facilities achieved Gift Certification for the first time and six birthing facilities were re-certified.

Three regional breastfeeding coalitions: Central Louisiana Breastfeeding Coalition, Greater New Orleans Breastfeeding Awareness Coalition, and the Acadiana Breastfeeding Coalition, are functioning. With participation of local breastfeeding support groups, the Louisiana WIC Program, the Louisiana Maternal Child Health Coalition and the American Academy of Pediatrics breastfeeding coordinators, the Louisiana Breastfeeding Coalition (LBC) was formed. The work of the LBC is guided by a 12-member Steering Committee. The primary purpose of the LBC is to make breastfeeding the norm for all babies in Louisiana. The LBC protects, promotes and supports breastfeeding through a variety of means including: improved public policy, professional education, use of the media, information sharing among lactation consultants, and development of regional/local coalitions. The LBC held its Inaugural Meeting on September 17, 2008. The LBC continued to build its membership and conducted regular steering committee and general membership meetings.

Infrastructure Building Services
An evidence-based, breastfeeding training program, offering 6 nursing continuing education hours, for hospital staff and community breastfeeding health care workers (i.e. La Leche League Leaders, WIC Breastfeeding Peer Counselors) was developed and offered in each region. The trainings included: evidence-based breastfeeding support as it relates to The Gift and local and national breastfeeding resources. From November 2008 to June 2009, a total of 540 people were trained during 18 trainings sessions in almost all regions of the state. Across all regions, both the presentation and the presenter received ratings of excellent by the majority of participants. Pre- and Post- tests were given to all training participants. The Pre-test score average was 76.91% and Post-test score average was 98.38%.

The Gift Statewide Coordinator held meetings with hospital administrators and staff. Presentations were given at two Fetal and Infant Mortality Review (FIMR) Community Action Team meetings to increase knowledge of breastfeeding and support for The Gift. Routine follow-up, including a mid-certification survey, was conducted with Gift Certified facilities. The Gift and the LBC were exhibited at statewide conferences.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provision of manual, hospital grade and portable electric breast pumps.		X		
2. Collection and analysis of WIC breastfeeding initiation and duration at 6 months of age rates.				X
3. Revision of breastfeeding policies and procedures including on-line breastfeeding training for all clinic staff and monitoring of				X

positive clinic environment that endorses breastfeeding.				
4. Provision of prenatal breastfeeding promotion bags to support breastfeeding initiation and duration rates.				X
5. Provision of trainings to promote new WIC foods for breastfeeding dyads to clinic staff and community partners.		X	X	X
6. Delivery of breastfeeding trainings with continuing education units for hospital staff and community breastfeeding health care workers statewide by The Gift program.				X
7. Provision of breastfeeding classes and breastfeeding peer counselors for prenatal, postpartum and breastfeeding participants to encourage and support breastfeeding initiation and duration.		X		X
8. Provision of new breastfeeding support and education materials on new WIC foods for breastfeeding clients.				X
9. Provision of support and assistance to birthing hospital administrators and staff to enroll their hospital in The Gift program.			X	
10. Establishment of breastfeeding worksite promotion and support along with provision of statewide radio PSAs.			X	

b. Current Activities

Population Based Services

Two birthing facilities were Gift Certified and two facilities were re-certified. There are 15 certified hospitals and 2 applications in process. The Gift Coordinator conducts follow-up surveys and obtain assurances from certified facilities regarding lactation support, staff education/training, and the handling of infant formula.

WIC is in the process of implementing statewide peer counseling coverage. As WIC continues to utilize and expand the breastfeeding peer counselor program, clinics have continued to provide breastfeeding education and support through classes, distribution of prenatal breastfeeding promotion bags, updates on the new WIC foods and breast pump assistance.

The Louisiana Breastfeeding Coalition is developing an organizational strategic plan.

Infrastructure Building Services

Five 6-contact hour trainings were conducted in four regions of the state. In the five trainings conducted, a total of 197 people were trained with a Pre-and Post-test scores were 71.88% and 98.18% respectively.

A 1-contact hour presentation discussing evidence-based breastfeeding practices and The Gift was applied for and implemented.

A World Breastfeeding Week (WBW) 2009 Press Release was created and disseminated. A WBW 2010 Proclamation and press release will be developed in collaboration with Louisiana Department of Health and Hospitals. WBW 2010 events are currently being planned by regional breastfeeding coalitions.

c. Plan for the Coming Year

Objective: Increase to 27 the proportion of mothers who breastfeed their infants at 6 months of age to 27 by 2011.

Population Based Services

To increase the prevalence of evidence-based breastfeeding practices in Louisiana birthing facilities and increase breastfeeding initiation rates statewide, implementation of The Gift will

continue. The Gift Statewide Coordinator will continue to conduct meetings and trainings with hospital staff, provide reports to OPH-MCH and collect data from certified facilities specific to breastfeeding rates, lactation support, staff education and training, and how infant formula is handled.

WIC will continue to utilize and expand the breastfeeding peer counselor program statewide to provide encouragement and support to participants prenatally as well as the breastfeeding moms. Clinics will continue to provide breastfeeding education and support through classes, increased distribution of prenatal breastfeeding promotion bags, implementation of the New WIC Foods and breast pump assistance. WIC will continue to focus on providing breastfeeding support to worksites in the state that promote and support their breastfeeding moms.

The LBC will finalize and implement its strategic plan, hold regular meetings, and participate in USBC/CDC and Regional Breastfeeding Coalition Bi-Monthly Tele-conferences.

MPH students from Tulane University SPHTM will continue working with The Gift, LBC and local breastfeeding coalitions to assist with program implementation, assisting local businesses/universities in establishing lactation support programs, and develop skills related to public health and breastfeeding promotion and support.

Infrastructure Building Services
The Gift's 1-contact hour presentation will be provided to birthing facilities in all regions. Four 6-contact hour trainings will be conducted in non-Gift Certified facilities. Birthing facilities that undergo the training will be required to submit a written breastfeeding policy and a plan for implementing the Ten Steps within 6 months of receiving the training to The Gift Coordinator.

WIC will continue to update community partners on new breastfeeding policies, New WIC Food packages that are supportive of and encouraging breastfeeding, and new breastfeeding education materials. WIC will provide radio PSAs statewide on the benefits of breastfeeding utilizing the Loving Support makes breastfeeding work campaign and on the state improvement rates for breastfeeding.

A web-based breastfeeding resource directory, provided through ZipMilk, a service of state breastfeeding coalitions, will be launched and promoted statewide. The directory will be utilized by providers and parents and will be linked to the Partner's for Healthy Babies hotline.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	95	98	98	98	98
Annual Indicator	96.3	95.9	97.4	97.1	96.9
Numerator	41228	52801	63223	62916	61916
Denominator	42825	55084	64878	64773	63922
Data Source				Early Hearing Detection and Intervention Database	Early Hearing Detection and Intervention Database
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and					

2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	98	98	99	99	99

Notes - 2009
Data is based upon the entire year.

Notes - 2008
Data is based upon the entire year.

Notes - 2007
Data is based on entire year. Data is final.

a. Last Year's Accomplishments
The goal of the Hearing, Speech and Vision (HSV) program is to meet the American Academy of Pediatrics' (AAP) 1-3-6 guidelines for screening, identification and intervention. These guidelines state that a newborn should receive a screening for hearing loss by 1 month of age, a diagnosis by 3 months of age and initiation of intervention services by 6 months of age. HSV continues it efforts to reduce the morbidity and developmental and educational delays associated with hearing loss. Hospital staff screened 97.19% of newborns born in Louisiana for hearing loss (62,913 out of 64,771). This represents approximately 99.57% of Louisiana's occurrent births. Data from 2007 represented 98.82% of occurrent births. This statistically significant increase can be attributed to data reporting monitoring conducted by HSV. One of the goals of the monitoring was to assure that birthing hospitals electronically report all births.

The estimate of percent of newborns that have been screened for hearing prior to hospital discharge is directly affected by hospital submission of transfer and death reports as well as HSV's methods of collecting these submissions. HSV's tracking and surveillance system has recently been modified to capture newborns that expired, in order to exclude this number from screening rate calculations. The system has also been modified to produce hospital stratified transfer data in order to acquire unreported screening results.

Both percentages of infants lost to follow-up or lost to documentation (ltfu/ltd) during 2008 and 2007 were approximately 36%. Although 36% is well below the national average, HSV will modify the follow-up system to further improve follow-up.

Direct Services
Direct services were performed by HSV audiologists providing a variety of audiological services for children who refer and lack insurance or access to services. They provided 569 hearing and speech screenings for infants and toddlers and 820 audiology evaluations to children eligible for Children's Special Health Services (CSHS).

Enabling Services
HSV disseminated informational brochures, in English and Spanish, for hospital distribution to parents. HSV provided in-services and written information to Primary Care Physicians (PCPs), who provide rescreening for infants for the purpose of educating them about Universal Hearing Screening and Intervention (UNHSI) and the importance of follow-up reporting. A draft of the parent resource guide was sent to parents of children diagnosed with a hearing loss as well as to the audiologists at Children's Hospital. Parent surveys were collected and evaluated to improve the HSV system. The Advisory Council revised guideline documents to reflect changes in the

2007 Joint Committee on Infant Hearing Position Statement. The statewide Parent Consultant position was filled in January 2009. She is the parent of two deaf/hard of hearing children with cochlear implants.

Population-Based Services
HSV collected data on newborn hearing screening and continued monitoring and strengthening systems of follow-up to ensure that all infants referred received appropriate services. HSV also established a hospital monitoring project to monitor hospitals for data accuracy and completeness. HSV provided general technical assistance to hospitals in order to assure compliance with all components of the UNHSI system.

Infrastructure Building Services
Monitoring activities, training, and technical support services for system partners were conducted by HSV staff. Quarterly reports for screening and follow-up performance were provided to hospitals. Educational training was provided through the regional task force system as well as comprehensive hospital visits. HSV collaborated with Vital Records (VR) and the web-design consulting firm, DB SYSGRAPH INC in the re-engineering of the electronic birth certificate (EBC). The in-house IT consultant who was re-designing the hearing data system was permanently assigned to work on other assignments. HSV, the Parent-Pupil Education Program (PPEP) of the Louisiana School for the Deaf and EarlySteps (the Part C System) established a partnership to assure that PPEP will be the initial point of contact for children identified with hearing loss. Thus, families will have immediate access to a professional knowledgeable about hearing loss; PPEP will assure that families are referred to EarlySteps. HSV and PPEP provided training for EarlySteps providers.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide audiology follow-up for UNHSI where there is no access to community services.	X	X		
2. Provide hearing aids for identified children who have no access to community services.	X	X		
3. Provide parent education and outreach materials in English , Spanish and Vietnamese.		X	X	
4. Provide technical support to hospitals and primary care physicians.		X	X	
5. Maintain follow-up and tracking systems for children suspected of hearing loss.			X	
6. Award contract to establish the hearing screening and follow-up tracking and surveillance system.				X
7. Improve screening and follow-up tracking and surveillance system.				X
8. Provide training and standards for early hearing detection and intervention personnel.				X
9. Provide quarterly reports to hospitals.				X
10. Provide training to Early Steps providers.				X

b. Current Activities
Direct Services
Audiology services are provided by HSV audiologists in areas of provider shortages. The audiologist who provided CSHS services in Regions II and VII retired in October, 2009 and the position was lost. HSV is working to establish community-based services for affected children in these regions.

Enabling Services
Distribution of English and Spanish parent brochures is on-going. Technical support to hospitals continues. HSV continues to work with PCP offices to improve follow-up reporting. Guideline documents are distributed to stakeholders throughout the state.

Population-Based Services
HSV regularly maintains the Intervention Services database of children identified with hearing loss. The follow-up coordinator reduces the number of infants that are ltfu/ltd by contacting and connecting families and service providers. A fax back system is used to facilitate families returning for rescreening and to communicate with the medical home. Other systems, such as Women, Infants and Children (WIC) and CSHS are used to update family contact information and encourage return for testing.

Infrastructure Building Services
HSV submitted a request for proposals to create a web-based HSV tracking and surveillance system. HSV provides quarterly data reports to hospitals. Additionally, HSV and PPEP continue to train EarlySteps providers to encourage coordination of services with PPEP so that children referred for early intervention receive appropriate services without delay.

c. Plan for the Coming Year
Objective: To increase the proportion of newborns that are screened for hearing loss before hospital discharge to 98%. The goal for number of infants screened will remain at 98%, until VR and our hearing data collection can be changed to electronically report infant transfers and deaths. Although data on transfers to hospitals with neonatal intensive care units as well as death data can be entered into the current data system, only 32% of transfer newborn hearing screening results are being reported by hospitals that receive these newborns. Considering the increased risk of hearing loss associated with NICU care, efforts will continue to encourage transfer hearing screening report submission by hospitals receiving these infants.

Direct Services
Screening and follow-up services will continue to be provided by the HSV audiologists where there is a lack of audiology services in the private sector. The HSV program audiologists will continue to foster partnerships in the private sector. Children screened by CSHS in Region VII will be served by the audiologist at LSUHSC in Shreveport, working with CSHS staff in that region. Children in Region II who need services will be referred to other adjacent regions or to private providers in the area.

Enabling Services
HSV continuously distributes brochures and resource documents. Efforts will be made to develop brochures in Vietnamese and hospitals will continue to receive technical support. HSV will work to improve EI access and tracking for children who are deaf or hard of hearing including continued Part C training. The follow-up coordinator will continue efforts to reduce the number of newborns ltfu/ltd by contacting families to improve return for follow-up appointments and reporting follow-up statistics to audiologists. HSV staff regularly provide educational information to PCP offices that conduct follow-up rescreening, and monitor their reporting.

Population-Based Services
Emphasis for the coming year remains on hospital technical support, improving the screening, follow-up and intervention tracking and surveillance system and maintaining the Intervention Services data system for tracking children identified with permanent childhood hearing loss (PCHL). Additionally, HSV will work to increase the hospital rates of reporting transfers and deaths. HSV anticipates that the Louisiana Electronic Events Registry System (LEERS) will be implemented by Vital Records, and HSV will continue to receive hearing data electronically from this system.

Infrastructure Building Services
HSV will work to develop a complete web-based data collection system once the contract is executed with the company awarded the work through the RFP process.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	13	7	9	9	8
Annual Indicator	9.9	16.7	12.3	11.7	11.7
Numerator	111448	189258	143425	137156	137156
Denominator	1121605	1130575	1167153	1174079	1174079
Data Source				AAP Child Health Insurance Report	AAP Child Health Insurance Report
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	8	8	8	8	8

Notes - 2009
Data is provisional ans based upon the 2008 data.

Notes - 2008
Data is final and is based upon the AAP Children's Health Insurance Status and Medicaid/CHIP Eligibility and Enrollment, 2008 – State Reports, September 2009.

Notes - 2007
Data is final and is based upon the AAP Children's Health Insurance Status and Medicaid/CHIP Eligibility and Enrollment, 2007 – State Reports, September 2008.

a. Last Year's Accomplishments
In 2008, the percentage of uninsured children from birth to 19 years was 11.7%. Though the 2008 performance objective of 9% uninsured children was not reached, the percentage of uninsured children in 2008 was lower than the 2007 and 2006 uninsured rate of 12.3% and 16.7%, respectively. The 2006-2008 estimates are from the AAP, Children's Health Insurance Status Medicaid/SCHIP Eligibility and Enrollment Reports dated September 2007, 2008, and 2009, respectively. Health insurance data for 2009 is not yet available.

Of note, the percentages of uninsured children under 19 years old reported in the Louisiana Health Insurance Surveys (LHIS), are lower than the percentages documented in the AAP, Children's Health Insurance Status Medicaid/SCHIP Eligibility and Enrollment Reports. According

to the 2009 LHIS report, the percentages of uninsured children in 2009 was 5.0%, which exceeded the 2008 performance objective of 9% uninsured children and is decreased from 5.4% in 2007 and 7.6% in 2005, and is much lower than the AAP uninsured rates of 12.3% for 2007 and 9.9% for 2005. LHIS results were based on over 10,000 Louisiana households representing insurance status for over 27,000 Louisiana residents and have been weighted with the most current population estimates available. However, the AAP results are based on the American Academy of Pediatrics analysis of the Annual Social and Economic Supplement , September 2009 Current Population Survey.

Enabling Services
The income eligibility for state-sponsored health insurance programs were checked for pregnant women, infants, and children accessing the Office of Public Health (OPH) Public Health Units (for WIC or other health services), School-based Health Centers (SBHC). Income eligible, uninsured infants and children were provided referral information on LaCHIP/Medicaid and an application. Income eligible, uninsured pregnant women were provided an application and referral information for LaMOMS/Medicaid. In subsequent visits, those who were still eligible and uninsured were offered additional assistance and another application for the respective programs.

Population-Based Services
The MCH Program continued to work with the Department of Health and Hospitals' Covering Kids & Families (CKF) Coalition Project, a state-funded, statewide, community-based outreach and education project consisting of 11 regional coalitions that provided families of eligible children enrollment assistance into LaCHIP. In February 2009, DHH implemented the Louisiana MaxEnroll Initiative, which is a four year project funded by the new Robert Wood Johnson Foundation's Maximizing Enrollment grant to enroll 98% of eligible children in Medicaid or LaCHIP by year 2013. One of the strategies used to achieve this goal is Express Lane Eligibility (ELE), a process that allows DHH to use an eligibility determination by another approved agency to determine eligibility for LaCHIP and Medicaid.

Infrastructure Building Services
The MCH Program worked with the State Medicaid and LaCHIP staff to provide updated information regarding its services to clients in OPH Parish Health clinics statewide and to provide technical assistance, particularly in the area of access to services and enrollment. The MCH Program maintained representation on the Louisiana Covering Kids and Families Coalition's Advisory Committee and participated in statewide coalition meetings. Also, representatives of the Medicaid Program served on the BrightStart (Louisiana Early Childhood Comprehensive Systems-building Initiative) Steering Committee to provide updated information that addressed the "access to care and medical homes" priority area.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Eligibility screening for Medicaid/LaCHIP/LaMOM for all infants, children, & pregnant women seen in OPH.		X		
2. Provide Medicaid eligible clients with information on Medicaid/LaCHIP and LaMOMS and how to apply.		X		
3. Support the outreach and enrollment efforts of Medicaid's MaxEnroll Initiative and of the SBHCs.			X	
4. Technical assistance to the LaCHIP, LaMOM, and Medicaid Programs for enrollment eligibility and access to services.				X
5. Maintain MCH representation on the Louisiana Covering Kids and Families Coalition's Advisory Committee.				X
6. Medicaid representation on BrightStart's Advisory Council.				X
7.				

8.				
9.				
10.				

b. Current Activities

Enabling Services

Income eligibility for state-sponsored health insurance programs are checked for pregnant women, infants, and children accessing OPH Public Health Units and SBHCs. If any families screened are income eligible and uninsured, then they are given referral information and a joint application for Louisiana Medicaid/CHIP. Print and online enrollment information are available in Spanish and Vietnamese.

Population-Based Services

The MCH Program continues to work with Louisiana Covering Kids and Families Coalition Project and to support the efforts of the with the new Robert Wood Johnson Foundation's Maximizing Enrollment grant, MaxEnroll, to enroll 98% of eligible children in Medicaid or LaCHIP by year 2013.

Infrastructure Building Services

MCH continues to work with State Medicaid and LaCHIP staff to provide updated information regarding its services to clients in OPH Parish Health clinics statewide and to provide technical assistance, particularly in the area of access to services and enrollment. MCH has representation on the Louisiana Covering Kids and Families Coalition's Advisory Committee and Louisiana Medicaid has representation on the BrightStart Advisory Council (Louisiana's MCHB ECCS Grant Initiative) to give updated information on "Access to care and medical homes".

c. Plan for the Coming Year

Objective: Decrease the percentage of uninsured children to 8%.

Enabling Services

Parish Health Units will continue screening and referral of those uninsured infants, children and adolescents who are eligible for LaCHIP/Medicaid services as well as pregnant women to LaMOMS/Medicaid.

Population-Based Services

The MCH Program will continue to work with Covering Kids and Families Coalition and Medicaid's MaxEnroll outreach efforts to increase enrollment of eligibles into LaCHIP/LaMOMS/Medicaid Programs.

Infrastructure Building Services

MCH will continue to provide technical assistance to Louisiana Medicaid, to maintain its representation on the Louisiana Covering Kids and Families Coalition's Advisory Committee, and to maintain Medicaid's representation on the BrightStart Advisory Council.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective		12.5	12	11.5	11
Annual Indicator	13.2		13.8		12.4
Numerator	11781				

Denominator	89373				
Data Source				CDC PedNSS	CDC PedNSS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	10.5	10.5	10.5	10.5	10.5

Notes - 2009
Data is final.

Notes - 2008
The WIC Program's application developer has been working with CDC on the criteria required for data transfer to PedNSS. Due to budget constraints and the upcoming changes in the WIC food package, 2008 data has not been transferred to PedNSS at this time. It is our hope that in the future the WIC Program's data system will be updated to automatically generate reports to be submitted to PedNSS.

Notes - 2007
The WIC Program's application developer has been working with CDC on the criteria required for data transfer to PedNSS. The developer was able to transfer the WIC 2007 BMI data to be included in the 2007 CDC PedNSS report. Due to budget constraints and the upcoming changes in the WIC food package, 2008 data has not been transferred to PedNSS at this time. It is our hope that in the future the WIC Program's data system will be updated to automatically generate reports to be submitted to PedNSS.

a. Last Year's Accomplishments
BMI at or above the 85th percentile for children ages 2-5 decreased from 13.8% in 2007 to 12.4% in 2009.

Direct Services
WIC provided services in 113 locations for counseling and education sessions to families statewide on healthy eating and physical activity. Referrals were made to WIC for specialized nutrition counseling.

Enabling Services
The new WIC food package includes fruits, vegetables, whole grains, fat reduced milk and milk products. The changes address obesity concerns by improving the overall nutrient density of the packages, while keeping the caloric content the same or slightly lower. Ten newsletters and educational handouts were created and disseminated to WIC staff statewide. In addition, several staff trainings were conducted from May-August 2009 and 22 participant educational brochures, posters, and handouts were created and disseminated to all WIC participants.

The MCH Registered Dietitian (RD) provided training to 50 Child Care Health Consultants (CCHC) at the annual conference, covering food allergies, healthy eating and physical activity for children in the child care setting.

Population Based Services
For the second year through the Louisiana WIC Farmer's Market Program, 240 families received a one-time coupon booklet issuance to use at farmer's markets in New Orleans and Jefferson

parishes. In addition, the farmer's market project was promoted at special events including "Meet Me at the Market" days, a Farmer's Market Halloween party, and a Healthy Start "Mall of Moms".

WIC purchased 30,000 Sesame Street, "Get Healthy Now" DVD kits to distribute to families with children ages 1-5 years. The kit contained an interactive DVD, storybook, and guide for parents/caregivers and were available in English and Spanish. The kits were distributed from May-June 2009 to promote the new food package implementation and to encourage an increase in fruit and vegetable intake as well as an increase in physical activity.

The Southeast United Dairy Industry Association, Inc. provided the Louisiana WIC program with 1,000 "Cooking with Confidence" cookbooks, which were developed by Chef John Folse in cooperation with the Southeast Dairy Association. The cookbooks were distributed during June 2009 to coincide with National Dairy Month.

Infrastructure Building Services
The MCH RD actively participated in the Louisiana Obesity Council, who in 2007 obtained a $110,000 grant from the National Governor's Association to assess implementation of school wellness policies in Louisiana schools. Through this grant, a school wellness policy implementation toolkit was created and distributed to 924 schools across the state. The Obesity Council was a sponsor of the second, statewide Childhood Obesity public health conference, at which Louisiana was assigned a grade of D for the second year.

The MCH RD collaborated with WIC to determine obesity education materials currently being used in statewide WIC clinics. A survey was disseminated to WIC staff to determine which resources are currently being used and what resources are lacking. The MCH RD and WIC nutrition education coordinator will use the results of the surveys to develop and/or revise obesity education materials.

The MCH RD continued to serve as the co-chair of Louisiana Action for Healthy Kids (LA AFHK). Louisiana has over 300 members from across the state. In January 2009 LA AFHK held its second annual state meeting, where approximately 60 team members and stakeholders gathered to collaborate and discuss initiatives occurring across the state in regards to childhood obesity. In July 2009 LA AFHK received $5000 in funding to promote the Fuel Up to Play 60 program, a program through the National Football League and the National Dairy Association aimed at increasing healthy nutrition and physical activity in adolescents. Through this funding LA AFHK awarded $500 mini-grants to 9 schools to help implement the program and create awareness to healthy nutrition and physical activity. Through funding from AFHK, the Obesity Council was once again able to provide a monetary award to the 2 school winners of The School Health Awards.

The MCH RD participated on a committee with the Louisiana Department of Education to help to establish and implement health curricula in all public elementary and secondary schools. The committee's work is currently under review and is anticipated to be implemented in the 2011-2012 school year.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Counseling and education sessions to families on healthy eating and physical activity.	X			
2. Referrals to WIC Services for specialized one-on-one nutrition counseling.		X		
3. Utilization of educational materials on healthy weight & physical activity for infants and children.		X		
4. Training of health professionals to enhance their abilities to				X

promote healthy lifestyles with patients.				
5. Participation in the Louisiana Obesity Council and other committees.				X
6. Implementation of guidelines for health professionals on healthy weight and physical activities.		X		
7. Training for health professionals to utilize new methods of nutritional assessment of children age 2 -5.		X		
8. Outreach activities to encourage families to increase consumption of fruits and vegetables.			X	
9.				
10.				

b. Current Activities

Enabling Services

In October 2009 the new WIC food package was implemented and promoted in WIC clinics statewide. In April 2010 the MCH RD participated in the MCH CCHC Conference and trained 100 professionals on healthy nutrition, food allergies, and food safety in the child care setting. In addition the MCH RD trained 40 staff at 5 childcare centers on the topic of healthy nutrition.

Louisiana MCH is working with Louisiana State University School of Public Health on a childhood obesity initiative to implement in Louisiana child care centers. The MCH RD continues to collaborate with NFP on developing a childhood obesity prevention initiative.

Population Based Services

The Louisiana WIC Farmer's Market Program will continue to be promoted in Orleans and Jefferson parishes. The program will also be expanded to Plaquemines parish and the Shreveport and Alexandria areas.

The MCH RD helped plan and coordinate the third annual state meeting for LA AFHK in March 2010. The MCH RD and WIC nutrition educator are working together to create new and revise existing obesity education materials based on the feedback received from the field survey.

Infrastructure Building Services

The MCH RD is working with the 9 FUTP 60 grant recipient schools to ensure implementation of the program. In addition the MCH RD and coordinator of the Louisiana Obesity Council are working with the DHH Tobacco Control program on a grant to assist local school boards with developing School Health Advisory Councils.

c. Plan for the Coming Year

Objective: Reduce the percent of children (2-5 years) receiving WIC with a BMI at or above the 85th percentile to 10.5%.

Direct Services

WIC will continue to provide services in OPH for counseling and education sessions to families statewide on healthy eating and physical activity.

Enabling Services

The MCH RD will partner with LSU on a childhood obesity initiative to implement in Louisiana child care centers. This initiative will focus on obesity prevention policies regarding nutrition and physical activity in Louisiana child care centers and will utilize the Nutrition and Physical Activity Self-Assessment for Child Care (NAP SACC) program. The MCH RD will also partner with LSU to explore funding to implement an obesity initiative within the NFP program aimed at educating mothers on appropriate weight gain during pregnancy and appropriate infant and toddler feeding techniques.

Population Based Services
The MCH RD will collaborate with the WIC nutrition educator to create new and/or existing WIC education materials related to obesity prevention, healthy eating, and physical activity. These materials will be made available in October 2010 and promoted in all WIC clinics. The MCH RD will also collaborate with WIC to train staff on the new Institute of Medicine pregnancy weight gain guidelines, WIC policy updates, and obtaining growth measurements on infants and children.

The Louisiana WIC Farmer's Market Program will continue to be promoted. In addition 100,000 "More Matters" reusable grocery tote bags will be purchased to encourage WIC participants and caregivers of infants/children to utilize the Cash Value Voucher for fresh fruits and vegetables. The participants will receive the bags along with educational materials related to fruit and vegetable consumption. The bags will also be distributed to WIC Farmer's Market participants to encourage redemption of their farmer's market coupons. The WIC nutrition educator will also develop a cookbook that features recipes using fruit, vegetables, and whole grains. The cookbook is planned for distribution to WIC participants during September-December 2010.

The MCH RD will serve as a Child Care Health Consultant and will train the staff of at least 4 childcare centers on the topic of healthy nutrition.

Infrastructure Building Services
MCH and WIC will continue to actively participate in the Louisiana Obesity Council, Action for Healthy Kids, the Southwest Regional USDA committee, and the State Nutrition Action Plan committee. The MCH RD and Coordinator of the Obesity Council will continue to collaborate with the Louisiana DHH Tobacco Control to assist local school boards with developing School Health Advisory Councils and implementing comprehensive school wellness policies to prevent tobacco-use among youth and promote healthy eating and increase physical activity.

The Coordinator of the Obesity Council will assist in the planning for a third Childhood Obesity Conference and the Louisiana Report Card at PBRC.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		13.8	13.5	13.5	12.5
Annual Indicator	17.7	16.6	12.5	12.5	12.5
Numerator	11117	8358	7787	7787	7787
Denominator	62767	50494	62059	62069	62069
Data Source				LA Pregnancy Risk Assessment Monitoring System	LA Pregnancy Risk Assessment Monitoring System
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average					

cannot be applied.					
Is the Data Provisional or Final?				Provisional	
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	13.5	13.5	13.5	13.5	12

Notes - 2009
Data is preliminary ans based upon the 2008 data.

Notes - 2008
Data is based upon the 2007 data. The response rate for 2007 PRAMs data was 56% and should therefore be interpreted with caution.

Notes - 2007
Data is provisional and based upon 2006 PRAMS data.

a. Last Year's Accomplishments
Louisiana Pregnancy Risk Assessment Monitoring System (PRAMS) data for 2007 indicated that 12.6% of all pregnant women reported smoking during the last three months of their pregnancy, down from the 16.6% in 2006.

Direct Services and Enabling Services
The MCH program collaboration with Louisiana Section of American College of Obstetricians and Gynecologists (ACOG), state Office of Addictive Disorders (OAD), and Office of Mental Health (OMH) identified a screening tool for tobacco use in pregnancy, 4Ps Plus, that also screens for substance abuse, alcohol use, depression and domestic violence. State licensure for tool use and data collection from Dr. Ira Chasnoff of the Children's Research Triangle includes the tool and training for obstetrical providers within the state through (SBIRT-HBI) Screening, Brief Intervention, Referral and Treatment -- Healthy Babies Initiative Program for Pregnant Women. SBIRT screening in OPH-WIC sites (n=8360) cumulative (7/16/05-12/30/09) indicate 14.4% of women used tobacco cigarettes since they knew they were pregnant. Private and clinic prenatal offices (n=10514) cumulative (5/05/05-12.30/09) indicate 18.3% of women used tobacco cigarettes since they knew they were pregnant. CY2009 screens in WIC sites (n=4117) identified 17.8% and in non-WIC (n=2553) that 20.9% used tobacco cigarettes since they knew they were pregnant. In CY2009, 5.3% of pregnant women in non-WIC sites and 9.1% in WIC sites accepted referrals for smoking cessation to smoking cessation programs, 1-800-QUIT-NOW or FAX-To-Quit proactive tobacco cessation line .The Nurse-Family Partnership (NFP) nurse home visitors provide health education on smoking cessation, referrals, education, guidance and support to first time, low income mothers. MCH continued support for Partners for Healthy Babies, a comprehensive helpline and web site for client information on healthy pregnancy, including focus on smoking cessation in pregnancy. Callers to the Partners helpline are directly referred to the Louisiana Tobacco Quitline (1-800-QUIT-NOW). The Helpline received approximately 3,600 calls in FY 2009. The PHB websites received 18,147 webvisits, 15,238 unique visitors and 39,464 pageviews in CY 2009.

MCH continued collaborations, support, technical assistance, health information to 4 Healthy Start programs in 5 regions. MCH continued close collaboration with state March of Dimes CenteringPregnancy program and for Mom & Baby Mobile Health Vans in New Orleans (primarily Latina) and Lafayette.

Infrastructure
SBIRT collaborations continued with state Tobacco Control Program, March of Dimes, LPHI, OAD and Medicaid to promote smoking cessation among pregnant women. Regional coordinators in 7 regions of the state provide treatment resources and coordinated referrals.

Regional FIMRs identified tobacco use as a risk factor in poor pregnancy outcomes and began strategies for intervention on a community-wide basis.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide screening and referral for smoking cessation.	X	X		
2. Collaborate with OAD to initiate statewide risk screening.			X	X
3. Provide Smoking cessation programs for pregnant women using fax quit lines and direct counseling.	X	X		
4. Support Partners for Healthy Babies public information campaign for prenatal health.			X	
5. Provide Fetal and Infant Mortality Reduction Initiative in each region of Louisiana.		X		X
6. Provide Pregnancy Risk Assessment Monitoring System (PRAMS) surveillance system.				X
7. Collaborate with Medicaid to promote and reimburse for statewide risk screening /intervention.			X	X
8. Collaborate with LPHI, DHH-Tobacco Control Program, ACOG, private and public providers and Medicaid to decrease tobacco use in pregnant women.				X
9. Continue to collaborate with Louisiana Bureau of Minority Affairs to increase awareness of tobacco use, poor birth outcomes and SIDS.				X
10. Collaborate with WIC to provide screening, brief intervention and referral.	X	X		

b. Current Activities

Direct and Enabling Services

SBIRT continues in 8 of the 9 DHH regions in private and public prenatal offices and in OPH-WIC sites statewide. FAX-TO-QUIT proactive cessation counseling assistance for smoking cessation continues through the DHH-TCP. Nurse-Family Partnership (NFP) nurse home visitors program continues to provide health education on smoking cessation, referrals, education, guidance and support to first time, low income mothers and has expanded to 52 parishes, covering all regions of the state.

Population-Based Services

The PHB campaign continues web-based and multimedia approaches to promote healthy behaviors during pregnancy.

Infrastructure Building Services

The FIMR Community Action Teams provide local infrastructure to address tobacco use. FIMR continues collaborations with faith-based groups in 2 areas of the state, and initiated health ministry trainings for 14 churches in central Louisiana. A contract with LPHI provides a MCH coordinator for tobacco cessation efforts statewide among all agencies. Updated regional resource directories are disseminated. Louisiana Medicaid is implementing a requirement that all pregnant women be screened for tobacco use, effective October 2010. MCH, SBIRT, and the Tobacco Control Program are collaborating on private and public training on smoking cessation.

c. Plan for the Coming Year

Objective: Reduce the percent of women who smoke during the third trimester to 12.0%

Direct Services

The SBIRT-HBI program will continue to expand statewide among private obstetricians and WIC clinics throughout the state. Implementation of Medicaid requirement for all obstetrical providers to screen pregnant women for tobacco use will expand tobacco cessation counseling efforts statewide, in training providers and staff, and in increasing collaborations among agencies. The 4PsPlus tool is being provided to all obstetrical providers, and could potentially screen every pregnant woman in the state for tobacco use. Each region will have HBI coordinators and treatment resources. Epidemiological evaluation of the SBIRT-HBI program will expand.

Health units providing prenatal care will continue to screen for smoking and offer brief intervention and referral for cessation services. Family Planning is expanding screening to this population.

The Nurse-Family Partnership (NFP) nurse home visitors program provides education, counseling and referrals for women in need of these services.

Enabling Services
Ongoing contract with LPHI for an MCH Coordinator will expand collaboration with their extensive smoking prevention efforts. Regional FIMRs will continue to identify maternal tobacco use in infant and fetal death reviews. Client education materials will continue to be provided through SBIRT and DHH-TCP.

The NFP program will continue to address tobacco use during pregnancy, and provide education, counseling and referrals for women in need of these services.

Population-Based Services
The Partners for Healthy Babies program continues to address smoking as a risk factor in pregnancy. State PHB helpline 1800-251-BABY (2229) provides information in Spanish; translation services are provided through language line. LPHI will continue to develop and address smoking prevention media messages (including second hand smoke) for the maternal and child health population. FIMR coordinators continue collaboration with Office of Minority Health Access for April Minority Health Awareness programs among African Americans, faith-based groups, Healthy Start clients, and among Latinas in the New Orleans area.

Infrastructure Building Services
Medicaid will begin reimbursement for screening and intervention. Maternal tobacco use will continue to be addressed by regional FIMRs. Faith based groups will be offered cessation training. Cessation awareness campaigns will continue. Regional resource directories and collaboration with DHH-TCP Fax-To-Quit trainings will continue. FIMR regional programs continue to expand into additional parishes.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	8.8	9.3	8.8	8.8	8.8
Annual Indicator	12.0	5.6	7.7	5.2	5.2
Numerator	41	18	25	17	17
Denominator	342664	322799	323073	328634	328634
Data Source				Louisiana Vital Records and Statistics	Louisiana Vital Records and Statistics
Check this box if you cannot report the numerator because					

1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	7.7	7	6.5	6.5	6.5

Notes - 2009
Data is provisional and based upon the 2008 data.

Notes - 2008
Data is provisional.

Notes - 2007
Data is final.

a. Last Year's Accomplishments
Because of the sudden increase in suicide deaths among teens in 2005, analyses were performed to look at rates by race and occurrence of deaths by month, day, and parish of residence. These analyses did not show any clear evidence of any error that might account for the increase. Rates increased among both white and black teens and occurred across various months and Louisiana parishes. Because no evidence of errors could be found, the reported increase for 2005 will remain in the data as an unexplained increase for a single year. Although we should never interpret our data based on what particular statistics say, a statistical procedure known as join point regression, using data from 2000-2008, did not use 2005 as a cutpoint, meaning that it did not consider the increase in the calculation of trend. The program indicated a 1.7% annual decrease in suicide over the 9 year period.

Direct Services
Louisiana Office of Public Health Adolescent School Health Initiative Program (OPH-ASHP) continues to provide direct behavioral health counseling and referral to Louisiana's youth. There were 66 School Based Health Centers (SBHCs), 62 of which were funded by OPH-ASHP. Behavioral health concerns remained among the top 2 most common reasons for visits to SBHCs in both urban and rural areas of Louisiana.

Population-based Services
The Louisiana Office of Mental Health-Louisiana Partnership for Youth Suicide Prevention (OMH-LPYSP) continued its media campaign by funding busboards, billboards, and movie theater PSAs. Ten bus boards ran on New Orleans public buses for 3 months for a potential audience exposure of 5 million people. Billboards were posted in parishes along the roads to Baton Rouge and New Orleans for 1 month. Nineteen movie theaters in New Orleans, Baton Rouge, Lafayette, Lake Charles, Shreveport, Monroe, Alexandria, New Iberia and Slidell ran PSAs for 1 month for a potential audience exposure of 1.25 million. The national SAMHSA-AD Council TV PSA that was localized for the LPYSP was used.

Infrastructure Building
Louisiana Public Health Institute (LPHI) was in its third year of a Kellogg Foundation $8.7 million dollar grant award to re-establish SBHCs in the greater New Orleans area. These dollars continued to be used for construction of SBHC facilities and clinical services including expanded behavioral health services in elementary schools that do not have a SBHC among other things. As part of the behavioral health component of the initiative, LPHI-Kellogg dollars continued to fund a part-time psychiatrist within 4 of the OPH-ASHP SBHCs. The psychiatry component

received additional support from the Primary Care Access and Stabilization Grant (PCASG), also administered through LPHI. PCASG dollars were awarded to the Metropolitan Human Services District to hire an additional psychiatrist part time and services were expanded to additional schools that did not have SBHCs.

OPH/ASHP collaborated with Office of Mental Health (OMH), the Office of Addictive Disorders (OAD), and the Department of Education (DOE) to develop strategies for expanding behavioral health in schools without SBHCs. OPH-ASHP's collaboration with the DOE especially focused on the implementation of coordinated school health initiatives.

The OMH-LPYSP sponsored 9 events in to raise awareness about the importance of the program and suicide prevention. These events included a suicide prevention walk, a youth rally on the steps of the state capitol, a statewide poster/essay contest for school students, the third annual suicide prevention conference for professionals, teen screenings at schools and various local coalition sponsored activities. A grand total of 2,207 people participated in these 9 events. OMH-LPYSP continued to build support for the program through presentations at national, regional, and state conferences and meetings. LPYSP has established partnerships and linkages with nearly 200 state and national agencies.

A total of 24 people were trained in the ASIST Trainings for Trainers (T4T) model. These newly trained trainers provided a total of 28 ASIST trainings statewide with an approximate total of 523 participants. LPYSP conducted 6 Safe Talk sessions with an approximate total of 216 participants and a Safe Talk Training for Trainers with 9 people trained. A total of 1,192 people participated in the Suicide 101 Trainings.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide mental health counseling and referrals through School-Based Health Centers.	X			
2. Participate as a member of the Louisiana Youth Suicide Prevention Task Force.				X
3. Facilitate youth suicide awareness activities with the Foster Care and Juvenile Justice systems in Louisiana.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Direct Services

OPH-ASHP currently has 65 state funded SBHCs, with an additional 7 privately funded sites, for a total of 72 SBHCs statewide. These sites provide access to approximately 60,000 students. Behavioral health continues to be the second most common reason for a SBHC visit.

Infrastructure Building

OPH-ASHP continues to collaborate with the Office of Mental Health (OMH), the Office of Addictive Disorders (OAD), the Department of Education (DOE), and the Picard Center to expand behavioral health in schools without SBHCs through coordinated school health initiatives. The collaboration has proposed an expanded role for school social workers and is seeking approval

for Medicaid reimbursement for certain services that school social workers can provide.

Through a Robert Wood Johnson grant that Louisiana Public Health Institute (LPHI) received, SBHCs in the New Orleans Metropolitan area have adopted eClinical Works as their electronic medical record. This EMR is facilitating increased continuity of care for students in the SBHCs and allows the SBHC sponsor to increase billing revenues which contribute to the overall sustainability of the centers, including the behavioral health component.

OMH_LPYSP assists regional efforts to develop goals and resources, and work towards specific outputs, including toolkits, resource guides, and school prevention plans.

c. Plan for the Coming Year

OPH/ASHP hopes to expand the number of SBHCs in the coming year and behavioral health will continue to be a required full-time service within the centers. Unfortunately, the grant funding for psychiatry in SBHCs in the New Orleans Metropolitan area will end in the fall of 2010. OPH/ASHP is working with LPHI, Communities in Schools, Family Services of Greater New Orleans to collaborate in leveraging dollars, personnel and other resources to expand behavioral health resources for adolescents within school settings.

The OMH-LPYSP will continue to provide general awareness and education, gatekeeper training, peer support, youth screening, infrastructure development and coalition building. Similar media campaigns, awareness events, and training sessions are being planned. Recently the LPYSP was refunded by SAMHSA for three more years as a part of a competitive grant process where only ten states in the nation were recipients of this grant. The total amount of the SAMHSA Garret Lee Smith Suicide Prevention Grant for the state of Louisiana is 1.5 million dollars.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	84.7	84.8	90	90	90
Annual Indicator	86.8	88.4	87.7	90.5	90.5
Numerator	1153	1194	1246	1242	1242
Denominator	1328	1350	1420	1372	1372
Data Source				Louisiana Vital Records and Statistics	Louisiana Vital Records and Statistics
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	90	90	90	90	90

Notes - 2009
Data is provisional and based upon the 2008 data.

Notes - 2008
Data is provisional.

Notes - 2007
Data is final.

a. Last Year's Accomplishments
The percent of very low birth weight (VLBW) births delivered at high-risk facilities increased steadily through 2004 but has fluctuated up and down over the past few years. In 2006, 88.4% of such VLBW deliveries occurred in the appropriate level facility. For 2007, the percent dropped to 87.8% while preliminary 2008 data indicate that Louisiana has surpassed the Healthy People 2010 goal of 90% for the first time. Specifically, the preliminary 2008 data indicate that 90.5% of all VLBW infant deliveries to Louisiana women occurred in Level III or higher facilities.

Infrastructure Building Services
The Louisiana Perinatal Commission formulates a State Perinatal Plan, adopting guidelines for maternal and neonatal care and requiring a concordance in level between obstetrical and neonatal services, i.e. for a neonatal Level III facility, obstetrical services should be of Level III as well. The Louisiana Office of Public Health (OPH) continued to provide epidemiological data analysis updates through presentations at Louisiana Perinatal Commission and regional Feto-Infant Mortality Review (FIMR) meetings. The MCH Program Director and the MCH Maternity Medical Director, as members of the Perinatal Commission, and the MCH Epidemiology (EPI) group, served as a resource for data and information to the Perinatal Commission regarding VLBW and other relevant MCH issues. The EPI group updated information on VLBW deliveries by level of delivery hospital.

The lead MCH epidemiologist, Maternity Medical Director, and Maternity Nurse Coordinator, continued to provide coordination to the Fetal Infant Mortality Reduction Initiative through regional FIMR meetings and a statewide Louisiana FIMR network meeting focusing in part on the 2010 Title V perinatal needs assessment. During 2008-09, the Louisiana FIMR network reviewed perinatal deaths in eight of the nine administrative regions to help identify important issues surrounding these deaths. While the FIMR groups are evaluating contributors to fetal and infant deaths, their work continues to focus heavily on the high numbers of preterm births and VLBW infants delivered in our state.

Perinatal Periods of Risk methodology, an analysis of infant mortality according to birth weight and age at death, was an important component of the analyses presented to assist with the needs assessment. Data indicated that VLBW births accounted for nearly half of the total feto-infant mortality rate, indicating that VLBW births and prematurity are important factors for Louisiana.

A Screening, Brief Intervention, Referral and Treatment (SBIRT) program was expanded, in conjunction with other state partners to screen/ treat pregnant women for substance use, tobacco use, alcohol use, depression, and domestic violence. The tool for this program is the 4Ps Plus developed by the National Children's Triangle of Chicago. The state group implementing the program is MCH, Louisiana Section of American College of Obstetricians and Gynecologists (ACOG), state Office of Addictive Disorders (OAD), and state Office of Mental Health (OMH). Screening was available through private provider offices and expanded to WIC clinics in eight of the nine regions throughout the state. Resource guides for SBIRT referrals were completed. It is hoped that with improved screening and treatment, VLBW births may decrease. Regional SBIRT coordinators provide technical assistance and promote screening.

MCH supported the CenteringPregnancy groups to help address prematurity and VLBW. MCH

also assisted with the three March of Dimes funded prenatal mobile vans that provide care, especially in the New Orleans area.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Study distribution of VLBW infants born at all levels in the state, by region & parish.				X
2. Analyze VLBW in lower level facilities by race, Medicaid status, and delivery hospital. Share results with stakeholders.				X
3. Update MCH Data Profiles with the most current data on percent of VLBW in Level III or higher.				X
4. Support MCH grants for the perinatal mortality reduction initiative.				X
5. Support and promote regional Feto-Infant Mortality Reviews (FIMRs).				X
6. Disseminate analysis findings to all regional FIMRs and Perinatal Commission.				X
7. Continue collaboration with March of Dimes and other community based groups through FIMRs.				X
8.				
9.				
10.				

b. Current Activities

The State Perinatal Plan continues to guide levels of maternal and neonatal care, with MCH monitoring VLBW births. Final 2007 data indicated little disparity by race in that 88.4% of white versus 87.4% of black VLBW infants were delivered in Level III or higher facilities. An analysis reviewing VLBW deliveries by race and Medicaid status, specific hospital identified potential avenues for intervention. Reducing the number of VLBW deliveries in only a few lower-level facilities will result in Louisiana exceeding the Healthy People 2010 goal of 90%. These results were shared with the MCH Title V Director, Maternity Medical Director, and Medicaid Medical Director for further planning and action.

MCH supports FIMRs in all nine regions statewide to review cases, conduct home visits, and coordinate Case Review Teams (CRTs) and Community Action Teams (CATs), and continue to support measures to decrease the number of VLBW births and to increase VLBW infants born at higher level facilities. Provider based SBIRT screening, brief intervention, referral and treatment program for pregnant women was expanded to all regions, and Medicaid provider reimbursement is under consideration. Pre and interconception care efforts to help prevent prematurity and low birth weight continue, including the Stork Reality Preconception Social Marketing Campaign and participation in a multi-state Medicaid interconception workgroup.

c. Plan for the Coming Year

Objective: The proportion of very low birth weight infants delivered at facilities for high-risk deliveries and neonates will remain at least 90% for all race groups. Preliminary data from 2008 indicate that while 90.5% of all Louisiana women delivered VLBW infants in Level III or higher facilities, the breakdown by race indicated that 90.2% of white, 90.7% of black, and 90.4% of other race women delivered VLBW infants in Level III or higher facilities. A major objective will be to maintain at least 90% of VLBW deliveries in Level III or higher not only overall but also in each race group.

Infrastructure Building Services
Updates to the regional FIMR groups on risk factors associated with VLBW births at lower level facilities will occur and additional vital statistics analyses will continue to be performed. Regional FIMR groups will continue to monitor factors associated with VLBW deaths through case reviews. Opportunity for community action where appropriate will be carried out through FIMR CATs. The provider based SBIRT screening / treatment program for pregnant women, now named the SBIRT -Healthy Baby Initiative (HBI), will expand to additional WIC and private providers. OAD is combining with Office of Mental Health, with Office of Behavioral Health(OBH) as new name. With OBH funding assistance, regional coordinators will continue in all regions of the state to assist providers in brief interventions, referrals and treatment. Each region will update the resource guide for referrals and treatment, which is available to all interested providers. The OPH maternity program, in collaboration with regional FIMRs, will continue to refine disaster plans that are in place for pregnant women and newborns. This includes plans for evacuation of inpatients and care for evacuees that may be pregnant. The Partners for Healthy Babies hotline is monitored and updated to provide accurate regional information. Discussions are ongoing with state Medicaid for reimbursement for utilization of SBIRT screening in pregnancy. Plans are in place to evaluate SBIRT program effectiveness. The Maternity Program Medical Director is working with MCH staff to design and implement an evaluation plan. Follow-up contact is expected to be made with the identified hospitals based on the data analysis report done this year. It is expected that specific hospitals will be contacted to help facilitate solutions to further improve the percent of VLBW born in level III or higher facilities.

MCH anticipates continued strengthening of collaborations. This includes March of Dimes, Louisiana MCH Coalition, CenteringPregnancy groups, mobile prenatal vans, other state agencies, provider groups, as well as other community based organizations. Through these collaborations, we hope to have a greater impact on the many factors that contribute to VLBW births, and where these births occur.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	85	86	87	88	89
Annual Indicator	87.1	87.1	86.9	86.8	86.8
Numerator	52290	54696	57097	56222	56222
Denominator	60058	62820	65731	64803	64803
Data Source				Louisiana Vital Records and Statistics	Louisiana Vital Records and Statistics
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	90	91	91	91	91

Notes - 2009

Data is provisional and based upon the 2008.

Notes - 2008
Data is provisional.

Notes - 2007
Data is final.

a. Last Year's Accomplishments
Early prenatal care has increased from 82.3% in 1998 to 86.9% in 2007. Louisiana ranks favorably among all the states. The preliminary 2008 rate is 86.8%.

Direct Services
For FFY 2009, comprehensive prenatal care services were provided to 1,312 pregnant women through 4,782 visits via the statewide network of parish health units (PHUs). Over 14,553 pregnancy tests were performed. WIC benefits and health education were provided to 51,300 pregnant, post-partum, and breastfeeding women through the parish health units. In medically underserved areas, contractors provided prenatal services to 542 low- income women, with approximately 2,698 visits.

MCH collaborated with the March of Dimes (MOD) to continue prenatal care by mobile health vans in southern Louisiana and continued CenteringPregnancy with Latina women in New Orleans.

Enabling Services
The Nurse Family Partnership (NFP) provided home visits and case management to 2,654 first-time mothers for a total of 28,103 visits. Home visits are provided during pregnancy and continue until the child's second birthday.

MCH funds the Healthy Start Program in 4 northern Louisiana Parishes, which provided outreach/case management services to 176 pregnant women. Funding was provided for a part time mental health clinician at Healthy Start New Orleans, serving 30 pregnant women with perinatal depression or another mental health problem. MCH provided funding to Baton Rouge Healthy Start, which served 294 active clients in CY 2009 who received 4,091 Case Management services/visits. 1,279 Prenatal care visits were completed. Health Education was provided to 28,632 community participants through educational classes, groups, workshops and one-one sessions.

NFP teams continue to provide services and will continue to expand within the next year. Perinatal depression services were provided through Healthy Start New Orleans to 80 women, 21 infants, and 3 fathers through a HRSA grant.

Population-Based Services
The Partners for Healthy Babies (PHB) social marketing campaign added a campaign component to address preconception health- utilizing various tactics including traditional and new (social) media. Formative research is conducted to assure that the project remain culturally sensitive and competent. PHB website was revamped to be more user friendly for both providers and consumers. The Helpline received approximately 3,600 calls in FY 2009. The PHB websites received 18,147 webvisits, 15,238 unique visitors and 39,464 pageviews in CY 2009.

Infrastructure Building Services
Technical assistance was provided in all regions participating in prenatal services. All sites were found to provide adequate services; problematic issues were addressed through follow-up. Parishes in the lowest quartile for late entry and inadequate prenatal care were identified. This information was provided to regional Infant Mortality Reduction Initiative coordinators and utilized in ongoing regional needs assessment and strategic planning. The March of Dimes provided

three mobile clinics and funded Centering Pregnancy programs, targeting Latina women in the New Orleans area. MCH worked closely with these programs.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provision of prenatal services via network of parish health units and contract agencies.	X			
2. Provide targeted case management programs, such as Nurse Family Partnership.		X		
3. Link women to prenatal care via the Partners for Healthy Babies social marketing project Helpline and promote preconception health.			X	
4. Collect and analyze PRAMS data to provide program direction.				X
5. Provide Quality Assurance and program monitoring of all MCH funded prenatal services.				X
6. Support Regional Infant Mortality Reduction infrastructure, at each regional level, using Coordinators.				X
7. Work with Medicaid to ensure access to early and comprehensive prenatal care services.				X
8.				
9.				
10.				

b. Current Activities

Direct and Enabling Services

In regions with provider shortages, MCH provides services through the PHUs and contract agencies. NFP continues to provide case management and home visiting. Prenatal clinics, outreach and case management are ongoing in Shreveport, Baton Rouge, Northeast Delta Region, and New Orleans with MCH support.

Population-Based Services

PHB is continuing to address preconception health through it's the Stork Reality Campaign. PHB to use a mix of communication strategies, (including new media and public relations) to promote preconception health, prenatal care, other behavioral risk factors , along with the helpline and website resources. The FIMR program continues to be supported by PHB via public relations assistance, and consultation. A Health Education/Communication Functional Group within MCH provides PR support, health education resources to MCH stakeholders.

Infrastructure Building Services

MCH continues to work to expand access to services, especially in south Louisiana, rural areas and areas of high infant mortality.

c. Plan for the Coming Year

Objective: Increase the proportion of infants born to pregnant women receiving prenatal care beginning in the first trimester to 90%.

Direct Services

In areas with poor infrastructure, MCH will continue to support access to care through PHUs, contracts, and Healthy Start initiatives. Parishes in the lowest quartile for late and inadequate prenatal care will continue to be identified. Regional IMRI Community Action Teams will be

alerted so that public and private providers can work together to improve entry to prenatal care.

Enabling Services
NFP teams continue to provide services and will expand within the next year. MCH will continue to provide support and funding for Healthy Start program in the state to support case management/outreach and address perinatal depression.

Population-Based Services
Partners for Healthy Babies (PHB) will continue to work to reach out to high-risk populations of the state, in particular to address disparities. PHB will conduct extensive media messaging, public relations, and other activities in these areas, with special focus on preconception health. Continued coordination is planned with the LaMOMS program to provide outreach to and recruitment of pregnant women. PHB will continue to train and support the regional FIMR Coordinators in public relations efforts/activities.

Infrastructure Building Services
The Louisiana Fetal and Infant Mortality Reduction Initiative (FIMRI) Community Action Teams (CATs) will expand their role to focus on low birth weight infants, disparities and to improving inter-conception and preconception wellness for all women. The Maternity Medical Director and Nurse Consultant are continuing the statewide visits to providers and hospitals of high-risk obstetrical populations.

The SBIRT Healthy Baby Initiative, providing screening and treatment for women with substance abuse problems, depression, and domestic violence will expand, in conjunction with other state partners. Screening is being implemented in WIC clinics statewide. Collaboration with Medicaid will continue with smoking cessation and periodontal care in pregnancy and will expand focus on substance use screening.

Continued collaboration with Partners for Healthy Babies will target both patients and providers on the need for early entry into care. Parishes with poor performance on early and adequate prenatal care will be identified, and given targeted technical assistance.

MCH will continue to monitor quality assurance systems at all levels. PRAMS data is being analyzed and the final report will be widely distributed to stakeholders and made available through the Internet.

D. State Performance Measures

State Performance Measure 1: *Percent of all children and adolescents enrolled in public schools in Louisiana that have access to school-based health center services.*

a. Last Year's Accomplishments

Direct Services
The number of students with access to Office of Public Health (OPH) Adolescent School Health Program (ASHP) school-based health centers (SBHCs) was 54,904 or 8% of the approximate 681,038 students enrolled in public schools. OPH-ASHP met its goal of 7.7% of students enrolled. There were 51 full-time and 9 part-time, OPH-funded SBHCs, for a total of 60 ASHP sites. Two ASHP sites that closed temporarily in 2008 did not reopen until late fall 2009. Additionally, there were 7 non-OPH funded SBHCs.

Infrastructure Building Services
OPH/ASHP awarded planning grants to 6 sponsors in FY 07-08; however, ASHP only received enough funding in FY 08-09 to award 3 implementation grants for planned sites to become operational. ASHP conducted technical assistance workshops for the previous year's 6 planning

grantees to respond to a competitive call for proposal for the 3 funded implementation grants.

The Louisiana Public Health Institute (LPHI) continued to support behavioral health services in SBHCs through dollars obtained in Kellogg funding and through an award of Primary Care Access and Stabilization Grant (PCASG) dollars to the Metropolitan Human Services District. In Year 2 of its Robert Wood Johnson (RWJ) multi-year grant, LPHI installed an Electronic Medical Record (EMR) in 5 SBHCs and provided training and technical assistance to help SBHC staff fully utilize the new system.

Because most SBHCs are SCHIP/Medicaid application centers, SBHC staff was able to maintain a low percentage of uninsured students enrolled in SBHCs at about 8%.

Six SBHC sponsors underwent a Continuous Quality Improvement (CQI) review, focusing on core sentinel conditions, including comprehensive physical exams, immunization rates, asthma management, data management, academic achievement, and health insurance enrollment. Random chart audits showed up-to-date immunization increased from 46% at the beginning of the school year to 79% by year end. For students receiving a comprehensive exam, 100% of audited charts documented STD screening, 100% showed tobacco screening and, if necessary, counseling to address tobacco use, and 89% contained a yearly height, weight, blood pressure and Body Mass Index (BMI).

ASHP continued its Best Practices Program. HIV/AIDS screening was added in 2007-2008 as a recommended, but not required, service at SBHCs housed in high schools. ASHP collaborated with the OPH HIV/AIDS program to provide the initial training to SBHC staff for onsite rapid HIV testing, follow up counseling, and referral. The HIV/AIDs program provided additional training and technical assistance in 08-09 and is available as an ongoing resource to SBHCs. SBHCs focused HIV/AIDS screening efforts on juniors and seniors to offer testing prior to students leaving high school.

ASHP assisted the Louisiana Obesity Council in its efforts to reduce obesity in Louisiana's young people by providing it with data on the prevalence of overweight students seen in SBHCs. Using the Center for Disease Control (CDC) formula which is specially designed to determine BMI categories for children, ASHP used 2007-2008 data on 11,800 students to determine how many fell within the designated weight ranges of underweight, normal, overweight/obese and obese. These data were some of the first statistics the Obesity Council had been able to obtain on the current Louisiana student population. In order to capture these data every year, ASHP staff asked the manager of its data collection system to incorporate the CDC formula into the data base, so that the weight categories can be calculated automatically in future years.

OPH/ASHP's continued to work with Louisiana Medicaid to establish a mechanism to implement reimbursement for behavioral health services in SBHCs. ASHP had previously obtained approval for this at both the state and federal level. ASHP continued to collaborate with the state Department of Education (DOE) on school health related Programs, especially coordinated school health initiatives. ASHP implemented a pilot project, made possible through a grant from Blue Cross/Blue Shield of Louisiana Foundation, to diagnose and treat hypertension in SBHCs. ASHP also began its Asthma Study, in collaboration with Medicaid, University of Louisiana at Monroe, & LPHI, to compare incidents of hospitalization and emergency room visits for asthmatics with access to an SBHC to those without access.
An attachment is included in this section.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. SBHCs provide comprehensive preventive and primary physical and mental health services.	X	X		

2. Set policies and standards for SBHC operation.				X
3. Provide technical assistance, monitoring, continuous quality improvement in SBHCs.	X			X
4. Work to raise level of funding to support SBHC operation.				X
5. Publish Louisiana School-Based Health Centers Annual Services Report.				X
6. Collaborate with various entities to promote coordinated school health model.				X
7. Provide resources to policy makers, educators, service providers, etc. on school health issues.				X
8. Generate statistical reports on service delivery in Louisiana SBHCs.				X
9. Engage in appropriate research activities that advance knowledge in the field of pediatric/adolescent medicine.				X
10. Implement statewide protocol for diagnosis and treatment of hypertension.	X			

b. Current Activities

Direct Services

In 2009, 3 new sites opened and 2 sites that were closed reopened. The current number of state funded SBHCs is 65, bringing the number of students with access to approximately 60,000 or about 9% of total enrollment.

Infrastructure Building

SBHC representatives are working to change Louisiana minor consent laws to include liability coverage for nurse practitioners.

Nine SBHC sponsors underwent on-site Continuous Quality Improvement (CQI) review. ASHP instituted a process to qualify non-OPH funded SBHCs as Medicaid providers, contributing to site sustainability. Ten SBHCs now have electronic medical records (EMRs). LPHI is working to finalize the interface between the EMRs and LINKS, Louisiana's Immunization Network, and to eliminate the redundancy of using both ASHP's current data system and EMRs. ASHP's work with Louisiana Medicaid to implement a reimbursement procedure for behavioral health services in SBHCs is on hold because of the state's current fiscal situation. Collaboration with DOE on coordinated school health initiatives continues. The Blue Cross/Blue Shield of Louisiana Foundation grant-funded pilot has resulted in hypertension screening of over 1,000 students at 5 SBHCs. About 50 students have been identified as having blood pressures high enough to warrant further testing and referral to a primary care physician. Data from the Asthma study conducted in the 2009 school year is currently being analyzed.

c. Plan for the Coming Year

Objective: Maintain the percent of all children and adolescents enrolled in public schools that have access to school-based health centers at an 8% level.

ASHP does not anticipate funding increases in its 2010 -- 2011 budget. Therefore, it does not expect expansion of the number of SBHCs. However, ASHP is preparing to apply for federal funding through opportunities offered in the new health care reform bill, dependent on the State's decision whether to apply for these federal dollars.

Direct Services

The ASHP Program will continue to fund, provide technical assistance, and monitor the state-funded SBHCs. Existing SBHCs will provide services to about 60,000 students in public schools. ASHP is preparing another proposal to Blue Cross/Blue Shield of Louisiana Foundation for grant funding to roll out the hypertension project to all 65 SBHCs statewide. ASHP will disseminate the

findings of the asthma study and incorporate any findings into its policies and protocols.

Infrastructure Building Services
ASHP will continue to certify non-state funded SBHCs that meet standards of care for Medicaid reimbursement as an SBHC provider type.

Despite the current hold on Medicaid billing for behavioral health services, ASHP will continue to develop strategies to expand school-based behavioral health services and to pursue other avenues that support funding for behavioral health services. ASHP's collaborations with the DOE, the LA Obesity Council, LPHI and the EMR project are ongoing. LPHI is negotiating with ASHP to provide technical assistance to more SBHCs statewide as sites consider adoption of an EMR

ASHP plans to conduct 11 CQI site visits in 2010-2011.

State Performance Measure 2: *Percent of women in need of family planning services who have received such services.*

a. Last Year's Accomplishments

The percent of women in need of publicly funded family planning services who have received such services was 23.3% in 2009 compared to 20.2% in 2008. In 2009, the numerator, number of women in need of publicly funded family planning services who have received such services includes Family Planning Program Annual Report (FPAR), Medicaid and Family Planning Take Charge Medicaid Waiver data. The number of female clients that received comprehensive reproductive health care services through the Family Planning Program (FPP) increased by 11% to 64,764 in 2009 from 58,158 in 2008. Medicaid prescribed oral contraceptives, IUDs, or performed tubal ligation/surgical procedures to approximately 62,604 women. According to the Guttmacher Institute, 2010, an estimated 509,010 women in Louisiana are in need of publicly funded Family Planning (FP) services. Of these, 287,660 women have incomes below 250% of the federal poverty level. In 2009, approximately 90% of FP female clients were at or below 100% Federal Poverty Level.

Direct and Enabling Services
The FPP provided FP services to women ages 19-44 through the FP Take Charge Medicaid Waiver Program. Take Charge Coordinators conducted outreach in the community and in the Parish Health Units. The Coordinators also tracked the application turnaround time for recertification. In September 2009, 62,772 women were enrolled in Take Charge.

Population Based
The FPP, with consultation from the Center for Health Training (CHT) made improvements in providing outreach to persons in need of family planning services. Using the results obtained from the needs assessments, the first state Health Education and Outreach Plan was developed and implemented in all FP service sites. The plan helps structure outreach activities, direct services where needed most, and provide strategies for attracting women who are in need of family planning services.

Infrastructure Building Services
The FPP provided more face-to-face and web-based trainings for Women's Health. FP clinic staff viewed webcasts on Cervical Cancer Prevention and Treatment, and Widening Birth Intervals in October 2008 and March 2009. In January 2009, staff viewed a videoconference on Screening for and Preventing Intimate Partner Violence. In May 2009, FP staff participated in a face-to-face workshop on Increasing Family Involvement with Teen Clients, and a video conference training on Preconception Care and Counseling.

Mystery Caller Assessments were conducted to assess the need of availability of services for the women in need of family planning services. The assessment identified clinic strengths and weaknesses in providing high quality services.

The FPP and MCH continued promoting folic acid supplementation to ensure all women of childbearing age intake adequate folic acid before and during pregnancy to help prevent birth defects. A folic acid information card was developed and piloted in a FP clinic. Clients as well as a statewide review committee provided feedback, and the folic acid information card became available in April 2009. The project was evaluated in July 2009 to determine the utilization of folic acid supplements by female clients. Upon completion of the evaluation, the findings identified barriers to folic acid distribution in FP clinics that included the ages of females who were most and least receptive to folic acid consumption; the knowledge level of the Public Health Nurses, Nurse Practitioners, and FP clients regarding folic acid; and reasons why clients did not take folic acid after it was given to them during their FP clinic visits.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provision of family planning services throughout the state in over 69 sites.	X	X		
2. Improving efficiency and quality of care in state-run and contract service sites.				X
3. Provision of community outreach and education to women in need of family planning services.		X		
4. Training of family planning service providers on topics that enhance family planning services.			X	X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Direct and Enabling Services

In February 2010, FP services were expanded to the Delgado Health Clinic, also known for servicing STD clients in New Orleans. Due to the high volume of clients served including high risk clients, and clients who are uninsured, this is an opportune site to provide FP services to women in need of such service.

State budget cuts resulted in elimination of Take Charge Coordinators late December 2009. The FPP continues to assist the state of Louisiana in obtaining and monitoring the Medicaid Waiver for FP services for women.

The FPP continues to collaborate with the STD Program on the Infertility Prevention Program, as well as the HIV/AIDS Program on providing region-specific HIV treatment resource information to FP clinics.

Population Based

Needs assessment activities are underway for the revision of the state Health Education and Outreach Plan. FP educational materials are available to the community and outreach activities are being conducted in all Regions.

Infrastructure Building Services

The FPP continues to work closely with the CHT on training activities and events. The FPP Women's Health trainings are still being held.

The FPP continues to distribute folic acid tablets and education regarding the importance of folic acid tablets to female clients seen in the FP clinics. The FPP recently developed a plan to increase the distribution, remove the barriers, and improve education among female clients who are of reproductive age.

c. Plan for the Coming Year

Direct Services

The FPP will continue to provide high quality family planning and reproductive health services to women in need of such service.

Enabling Services

The FPP will continue to collaborate with the STD and HIV/AIDS Programs. The FPP will continue to provide reproductive health and HIV prevention and referral to high risk women. HIV (+) or pregnant women in need of healthcare will continue to be identified and referred for services.

To increase the FPP's ability to serve the women in need of family planning services, the FP Take Charge Medicaid Waiver Program will continue to be promoted to all women ages 19-44 below 200% federal poverty level. Outreach will continue to be conducted in the community and in the Parish Health Units. Take Charge information and applications will continue to be available for women seeking FP services.

Population Based

The state Health Education and Outreach Plan will be revised to help increase utilization of services by the women most in need. The revised plan will help guide FP service sites with providing targeted outreach and education activities. Additional FP educational materials that address women's health will be made available upon approval from the state review committee. Educational materials and patient forms will continue to be translated in applicable languages for Limited-English-Proficiency clients.

Infrastructure Building Services

The FPP will continue to collaborate with the CHT on training activities and events. In addition to Women's Health videoconferencing, trainings will be conducted by face-to-face workshops, regional nurse meetings, and webinars. The FPP will continue to monitor and improve regional quality assurance activities in an effort to provide on-going, high quality family planning and preventive health services. FP services will continue to be monitored and corrective action plans will be developed to improve program performance.

The FPP will continue to collaborate with the Maternal and Child Health Program regarding the Folic Acid Project. The FPP will continue to offer folic acid supplementation and educational materials to all female clients of reproductive age. The FPP plans to conduct a series of focus groups to identify educational messages that will assist in increasing female's awareness regarding preconception care.

State Performance Measure 3: *Rate of children (per 1,000) under 18 who have been abused or neglected.*

a. Last Year's Accomplishments

During CY 2009, there were 19,246 validated allegations of abuse and neglect in children under age 18. The unduplicated count of 9,968 victims yields a rate of 9.0 victims per 1,000 children, an increase from last year.

Direct Services
Public Health Nurses (PHNs) were available, upon referral, to perform health assessments of children suspected of medical neglect from families under OCS (Office of Community Services) investigation. Two referrals were made to the PHNs by OCS to perform health assessments between October 2008 and September 2009.

The MCH-funded mental health services were provided to 210 women. MCH contracted with Project Last of the Children's Bureau of New Orleans to provide clinical grief/trauma assessments, home, school-based, family and group therapy, and crisis intervention services. Between October 2008 and September 2009, Project LAST served153 new families (276 adults and 192 children) impacted by violence (abuse, homicide, other), non-criminal deaths, traumas, SIDS, and other sudden unexpected infant deaths. Crisis intervention services were provided to 355 students and adults at schools which experienced loss of life and/or violence.

Enabling Services
Between October 2008 and September 2009, the Nurse-Family Partnership (NFP) program added a full team in the Capital Area Region and began a team in Region 9. The 16 NFP teams served a total of 2654 families in 52 parishes. Clinical trials and longitudinal studies show NFP significantly reduces validated child abuse and neglect.

Population-Based Services
Approximately 56,580 Happy and Healthy Kids parenting newsletters were distributed to parents via parish health units, provider offices, health fairs, and vital records complimentary birth certificates. The system to monitor/track distribution efforts through vendor reports, newsletter addendum, and annual reports continues to be implemented.

Infrastructure Building Services
Fifty three PHNs, social workers, and other professionals were trained in infant mental health (IMH). This 36-hour curriculum provides information and skills regarding early social-emotional development and parenting to improve identification of risk factors for child abuse and neglect, and cultural and ethnic influences on parenting. Availability of this program was extended to other state programs that serve infants and young children, including Early Steps, child protection, and Early Childhood Supports and Services (ECSS). The NFP Annual Conference included presentations on perinatal depression, PTSD, and cultural issues. A series of trainings to 10 Orleans Parish Healthy Start staff included overview and assessment of perinatal depression, IMH, and client comfort. Three Metropolitan Human Services clinicians were trained to provide perinatal mental health services, and 80 clinicians in southwest Louisiana received training on perinatal depression. In addition, 25 members of the Children's Cabinet Advisory Board received an awareness session about perinatal depression. Fifty clinicians attended a workshop on interpersonal therapy.

MCH continued to manage Louisiana Child Death Review, which includes state and local panels that review unexpected deaths of children under the age of 15 years, including SIDS. MCH Child Safety Coordinators continued to serve as the local Child Death Review Panel Coordinators. In 2009, at least 142 unexpected infant and child deaths were reviewed. Home visiting of families who lost an infant to SIDS/SUIDs was changed from a SIDS investigative/ fact-finding format to bereavement support visits, which included the revision of the home visiting policy and protocols, along with the development of a sympathy card and a standardized bereavement resource packet for families.

The Oral Health Program monitored the number of abuse and neglect cases reported by dental professionals; there were eighteen abuse and/or neglect cases in calendar year 2009; eight cases were validated, ten were not validated.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Child Health Record psychosocial assessment for children 0-6 in health units.	X			
2. Home visitation services for low-income families.		X		
3. Infant mental health services to low-income families through Best Start and NFP programs.		X		
4. Statewide training in infant mental health, perinatal depression, and related issues to public health nurses and other early childhood professionals.				X
5. Collection, analysis, and assessment of unexpected child deaths by the Child Death Review Panel.				X
6. Monitoring of child abuse and neglect referrals by dental professionals.				X
7. Public education through new parent's newsletter, Happy and Healthy Kids.				X
8. Targeted psycho-educational services for at-risk mothers.			X	
9. Targeted psycho-educational and support services for at-risk children and their families.		X		
10.				

b. Current Activities

Population-based services

MCH monitors distribution of the Happy and Healthy Kids newsletter via vendor reports and is exploring other methods for newsletter distribution and subscriber enrollment.

Direct Services

Public Health Nurses are available to perform health assessments of children suspected of medical neglect upon referral.

Community education, grief/trauma services, and crisis intervention services have continued to be provided by Children's Bureau's Project Last program to children and families in Orleans and Jefferson Parishes.

Enabling Services

NFP serves approximately 15% of all eligible mothers. Mental health consultation is now provided to eight of the 16 NFP teams. MCH continues to fund the Happy Mothers Happy Babies Program in Region 1, and the Best Start Program in Region 5.

Infrastructure Building Services

Fifty-six nurses and other professionals received the 36-hour Infant Mental Health training. Fifty-five clinicians in Region 5 were trained on dyadic treatment for perinatal depression; at the Zero to Three Conference in Dallas, 44 individuals received training on perinatal depression programs in Louisiana, and 52 on therapy techniques used with high risk mothers and babies.

The State and Local Child Death Review Panels continue to review unexpected deaths of children ages 14 years and under. Since October 2009, more than 40 cases have been reviewed, and a statewide child safety needs assessment was performed for ages 0-18 years.

c. Plan for the Coming Year

Objective: To reduce the rate of children (per 1,000) under 18 who have been abused or neglected to 8.8.

Direct Services and Enabling Services
A master plan for expansion of NFP services has been developed. Priorities include filling vacant positions; addition of new teams will be determined by area need and support and social and maternal child health indicators, as well as funding availability. Foundation support, legislative advocacy for state general funds, and expected federally legislated funds for home visiting are being pursued by OPH and community entities to further strengthen and expand NFP. The long term goal is for NFP to serve 50% of eligible first time, low income mothers and their infants. The Best Start program will continue to serve Region 5. The Happy Mothers Happy Babies program will offer assessment and treatment of perinatal depression and other mental health needs to clients served in Healthy Start and Orleans NFP programs. Community education, grief/trauma services, and crisis intervention services will continue to be provided to children and families in Orleans and Jefferson Parishes by Children's Bureau's Project Last. Public Health Nurses (PHNs) will continue to perform health assessments of children suspected of medical neglect.

Population-Based Services
MCH will continue to distribute the multicultural parenting newsletter, Happy and Healthy Kids, which focus on psychosocial development and positive parenting. Issues of the newsletter will continue to be distributed through public health units, provider offices, health fairs, and with the complimentary birth certificate provided to families by Vital Records. Ongoing evaluations will be conducted to guide future distribution mechanisms and operations.

The Oral Health Program will educate oral health professionals on reporting abuse and neglect through the Louisiana Dental Association Journal and the Louisiana Dental Hygiene Association Newsletter.

Infrastructure Building Services
Infant Mental Health trainings will be offered bi-annually. In addition, introductory trainings on infant mental health and maternal depression will be provided to other state and nonprofit agencies. The purpose is to increase awareness of these issues and facilitate appropriate referrals. Culture-specific issues are addressed in these trainings.

The State Child Death Review will continue to review child deaths under 15 years of age, including sudden unexplained infant deaths; support the local CDR panels' efforts; implement and/or promote effective injury prevention interventions at the state and local levels; improve case reporting; provide trainings on effective infant and child death investigations to CDRP members, coroners/medical examiners, and death scene investigators, and others involved in the investigative process.

State Performance Measure 4: *Percent of CSHS patients with case management (follow-up visits) from a nurse, social worker, or nutritionist.*

a. Last Year's Accomplishments
Direct and Enabling Services
CSHS provided follow-up services to CYSHCN attending clinic. The CC program expanded to another state region, and focused on transition CC for YSHCN. Staff helped families develop emergency preparedness plans and to relocate/return after the 2008 hurricanes. The nursing assessment was revised to include nutrition risk assessments. Nutritionist referrals were given for those with identified risks.

Population Based Services
The CSHS website was updated with community-based resources/events/information. Care coordinators in MH practices provided CC and transition services. The statewide care coordinator

supervisor increased CC capacity and thus access.

Infrastructure Building Services
A CC training was provided in February 2009 to region 6 staff, and supported with weekly technical assistance conference calls, and monthly visits. CSHS collaborated with F2FHICs to coordinate services between programs. CSHS volunteered to pilot data integration between DHH and DSS with the goal to increase efficiency and effectiveness of direct services provided to Louisiana CYSHCN eligible for state services.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Integrate activities from this SPM to the new SPM, to increase the care coordination capacity statewide.		X	X	X
2. Provide assessment and linkage to needed services for CYSHCN attending CSHS clinics and primary care practices who are receiving Medical Home Technical Assistance from CSHS.	X	X		X
3. Provide intensive care coordination services for children and families identified with high level of service need in 2 regions of the state, and expand this to 2 other regions.	X	X		
4. Provide case management services for CYSHCN attending CSHS clinics.	X	X		X
5. Provide technical assistance to Medical Home practices on issues related to facilitating care coordination services.			X	X
6. Train new staff on issues related to working with CYSHCN.	X		X	X
7. Train CSHS staff statewide on intensive care coordination services.				X
8. Collaborate with F2F HICs to coordinate care coordination services.			X	X
9. Participate in DHH/DSS data integration project to improve care coordination for CYSHCN.				X
10.				

b. Current Activities
Direct and Enabling Services
CSHS continues to provide follow-up services to CYSHCN attending CSHS clinics. CC trained staff are assisted by CSHS Central Office staff with program implementation questions. CSHS nursing staff continues to screen CYSHCN for nutrition risk factors and where appropriate refer to a nutritionist.

Population Based Services
The CSHS website is updated monthly. Care coordinators support MH practices. CSHS created resource guides for each region of the state for primary care practices.

Infrastructure Building Services
CSHS field staff in two regions was trained on CC. Activities for this SPM are being incorporated into the new SPM, to increase the state capacity to provide quality comprehensive care coordination services to CYSHCN and their families in Louisiana. A formalized process to disseminate information on community-based resources is collaboratively being developed with FHF. CSHS has continued to work with DHH and DSS in the development of the data integration project.

c. Plan for the Coming Year
Objective: To increase to 85% the percent of CSHS patients who have received case management (follow-up visits) from a nurse, social worker, or nutritionist.

Direct and Enabling Services
CSHS will provide follow-up services to CYSHCN attending CSHS clinics. CC training will expand, and trained staff will be assisted with program implementation questions by CSHS Central Office staff. CSHS nursing staff will to screen CYSHCN for nutrition risk factors and where appropriate provide a nutrition referral.

Population Based Services
The CSHS website will serve as an information portal for Louisiana CYSHCN, their families, and providers. Care coordinators will be expanded to MH Technical Assistance eligible practices. Resource guides will be disseminated to providers.

Infrastructure Building Services
Activities for this SPM will be further incorporated into the new SPM, to increase the state capacity to provide quality comprehensive care coordination services to CYSHCN and their families in Louisiana. Collaborative information dissemination on community-based resources will be provided to state program direct service providers. CSHS will work with the new policy leader for the DHH-DSS data integration project.

State Performance Measure 7: *Percent of women who use alcohol during pregnancy.*

a. Last Year's Accomplishments
2007 Louisiana Pregnancy Risk Assessment Monitoring System (PRAMS) data indicates that 5.5% of pregnant women reported drinking during pregnancy. This is a decrease from 8.9% noted in 2006 which was an increase from 2.9% in 2003.

Direct and Enabling Services
The MCH program in collaboration with Louisiana Section of American College of Obstetricians and Gynecologists, Louisiana Office of Addictive Disorders (OAD), and Office of Mental Health (OMH) utilize a screening tool for alcohol use in pregnancy. This tool, the 4Ps Plus, screens for substance abuse, alcohol use, depression and domestic violence. State licensure for tool use and data collection from Dr. Ira Chasnoff of the Children's Research Triangle was obtained. The tool and training are provided to obstetrical and WIC OPH providers statewide. This program is titled (SBIRT-HBI) Screening, Brief Intervention, Referral and Treatment -- Healthy Babies Initiative Program for Pregnant Women. Six of the 9 DHH regions were actively screening.

SBIRT cumulative data (5/05/05-12/30/09) shows that of the 10,514 pregnant women who were screened in non-WIC provider sites, 6.7% used alcohol since they knew they were pregnant. OPH-WIC sites (7/16/05-12/30/09) indicated 3.7% used alcohol. In 2009, six of the nine DHH regions screened 4117 pregnant women in WIC with 4.7% alcohol use, and obstetrical provider sites screened 2553 women with 7.8% alcohol use during pregnancy. SBIRT screens include the Brief Intervention for alcohol use during pregnancy as well as the message to all pregnant women screened on the danger of any alcohol use in pregnancy.

Discussion continued with Louisiana Medicaid to make SBIRT screening a pay for performance initiative for providers. The voluntary pregnancy testing program for OAD clients continued with 1,632 receiving tests. The positive pregnancy rate last year was 2.8%. This program allows more rapid diagnosis of pregnancy and referral for prenatal care. For those with negative tests, referrals are made for those desiring family planning services.

The Nurse-Family Partnership (NFP) nurse home visitors provided health education on alcohol use in pregnancy and smoking cessation, referrals, education, guidance and support to first time,

low income mothers in 52 parishes. MCH collaborated with the March of Dimes (MOD) to continue CenteringPregnancy programs.

Population-Based Services
The Partners for Healthy Babies (PHB) social marketing campaign added a campaign component to address preconception health- utilizing various tactics including traditional and new (social) media. The Stork Reality media program included video of in-person appearances of Sammy the Stork talking with young people in bars, restaurants, markets and parks about the dangers of alcohol use in pregnancy and the importance of healthy living prior and during pregnancy. Stork Reality included posters in restrooms statewide on "no amount of alcohol is safe in pregnancy" and streaming web video on the PHB website showing Sammy's discussions. Formative research is conducted to assure that the project remain culturally sensitive and competent. PHB website was revamped to be more user friendly for both providers and consumers.

Infrastructure Building Services
Substance abuse services continued to be identified as a priority need. The Fetal Infant Mortality Reduction Initiative (FIMR) focused on factors contributing to high infant mortality and prematurity rates. Alcohol use is a significant contribution to these rates. Regional Feto-Infant Mortality Reviews (FIMRs) are looking at problems and solutions at the local level. The MCH Maternity Medical Director and Nurse Consultant continued visits to OB Medicaid providers and birthing hospitals, providing education and resources. Discussion continued with Louisiana Medicaid to make SBIRT screening a pay for performance initiative for providers. The SBIRT Medical Director gave presentations at all regional FIMR medical meetings, at hospital medical meetings, in private provider offices and with regional and state Office for Addictive Disorders conferences and meetings on effects of maternal alcohol use during pregnancy. Regional SBIRT Coordinators conducted onsite technical assistance to SBIRT sites, trained an additional six obstetrical providers and 117 obstetrical staff, and gave presentations to nine provider sites, 124 regional medical and community groups with 5140 attendees.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue support of statewide perinatal substance abuse plan with the Office of Addictive Disorders and National Training Institute.				X
2. Support Home visitation to low-income mothers and infants.	X	X		
3. Support the Partners for Healthy Babies media and helpline.			X	
4. Support CenteringPregnancy groups.	X	X		X
5. Expand alcohol use in pregnancy screening to all regions of state and in WIC clinics throughout the state.	X	X		
6. Provide voluntary pregnancy testing and referral in Office of Addictive Disorder (OAD) clients.	X			
7. Support Partners for Healthy Babies Prenatal Care Fairs.	X			
8. Collaborate with Medicaid on Quality of Care issues and recommendations for funding substance abuse treatment.				X
9. Support regional Feto-Infant Mortality Reviews (FIMRs) to target substance abuse as one of leading risk factors for pre-term labor.				X
10. Collaborate with LPHI to support alcohol prevention messages and activities.				X

b. Current Activities

Direct and Enabling Services
SBIRT-Healthy Babies Initiative expanded services and are now in 8 regions with plans in place to expand SBIRT screening to all state WIC clinics by late 2010. Screenings in private provider offices continues to be a challenge and will be dependent on Medicaid future requirements for screening. An evaluation of SBIRT is being coordinated between MCH and Dr. Ira Chasnoff. The Family Planning program continues to address alcohol use in pregnancy in all areas of the state.

Population-Based Services
SBIRT and FIMR collaborated with Bureau of Minority Health Access to provide two health fairs in rural Grant Parish stressing the dangers of alcohol use in pregnancy and the need for healthier lifestyles before and between pregnancy. The PHB campaign continues efforts through in-person Sammy the Stork presentations in 4 regions including an appearance in Grant Parish on message of "no amount of alcohol is safe in pregnancy." PHB Stork Reality media campaign provided posters for restrooms on dangers of alcohol use in pregnancy.

Infrastructure Building Services
FIMR Community Action Teams (CATs) provide local infrastructure to address maternal alcohol use through education on dangers of alcohol use. SBIRT state medical director presented SBIRT at regional FIMR CAT and CRT meetings stressing the need for standardized message of "no alcohol use in pregnancy". SBIRT regional resource directories provide referral and treatment resources.

c. Plan for the Coming Year
Objective: Reduce the percent of women who use alcohol during pregnancy to 5.0%.

Direct and Enabling Services
The SBIRT screening tool is being made available to all obstetric providers with the goal of expanding the number of pregnant women exposed to alcohol and substance use screening. The use of screening tools in Family Planning clinics is being proposed. Using a model of interconception screening and intervention, Family Planning clinic sites will screen women for alcohol use with a modified 5P's Plus tool, and will provide Brief Intervention and referral to Office of Behavioral Health if indicated, thus increasing awareness of healthy behaviors in women of reproductive age. It is expected that interconception screening and intervention will reduced the number of women entering pregnancy with at risk alcohol drinking behaviors. Each region will have SBIRT-HBI coordinators and treatment resources. SBIRT coordinators will work with Family Planning clinic sites as a resource to facilitate implementation and conduct of interconception screening protocols.

Epidemiological and program evaluation of the SBIRT program will continue, providing feedback to MCH, OAD, SBIRT, and providers implementing the program. Health units providing prenatal care will continue to screen for alcohol and offer brief intervention and referral for cessation services. The NFP home visiting program will continue to address substance abuse during pregnancy and the interconception period, providing education, counseling and referrals for women in need of these services in all regions of the state.

Population-Based Services
PHB will continue the promotion of healthy pregnancy campaigns, with prevention of alcohol use in pregnancy as a part of that message. DHH Tobacco Control Program collaborating with PHB to increase media on smoking cessation during and post pregnancy.

Infrastructure Building Services
The SBIRT-HBI will continue to build local support for screening, intervention, treatment, and

prevention of alcohol use in pregnancy. Legislative efforts to criminalize pregnant women who use substances continue and are being countered by attempts to expand screening and access to treatment.

MCH will continue to meet with Medicaid to promote efforts to enhance quality of care issues and to implement a pay for performance for SBIRT screening / intervention. A statewide coordinator to address maternal tobacco and substance use has been hired with Tobacco Control Program and MCH Program funds.

State Performance Measure 8: *Rate of infant deaths due to Sudden Infant Death Syndrome.*

a. Last Year's Accomplishments
The Sudden Infant Death Syndrome (SIDS) death rate per 1,000 live births was 1.3 in 2007. The SIDS rate for African Americans in 2007 was 1.6. The SIDS rate for Caucasians in 2007 was 1.1. Overall the racial disparity for 2007 was 1.5. PRAMS data indicates that back sleeping has decreased from 56% in 2004 to 53% in 2007, after increasing from 32% in 1997.

Direct and Enabling Services
Children's Bureau continued to provide counseling for families of SIDS/ Other Unexpected Infant Death (OID) victims. Children's Bureau served 6 families with counseling and support for SIDS/OID and continued its network of parent peer contacts and community health educators to provide additional counseling and resources for SIDS/OID families. The Office of Public Health (OPH) provided counseling to 9 families in the rest of the state.

Population-Based Services
A social marketing public information campaign about SIDS and safe sleep environment continued to be implemented within high-risk areas of the state, with focus on creating a safe sleeping environment. The "Floor-Talkers" Project, a Fall 2009 in-store media messaging initiative, was identified as a promising practice, by the Association of SIDS and Infant Mortality Programs. Campaign efforts targeted racial disparities through the use of community and professional outreach. SIDS information continues to be distributed statewide to birthing hospitals, healthcare and daycare providers. The SIDS Program continued collaboration with community-based agencies to provide 150 educational sessions to daycare providers, public health nurses, social workers and the general public.

Infrastructure Building Services
The SIDS Medical Director reviewed autopsy and death scene investigations. The Louisiana Child Death Review Panel (CDRP) reviewed all unexpected deaths in children under age 15, including all SIDS deaths. There were a total of 47 sudden unexplained infant deaths that were reviewed by the Louisiana CDRP. The SIDS Program collaborated with Lake Charles regional medical director and staff in the first annual "SIDS Awareness and Safe Sleep" summit to focus on unsafe sleep practices while providing stakeholders with the tools to assist with educating the public. Participants consisted of nurses, social workers, faith-based communities, and foster parents. The CDRP in collaboration with the SIDS Program revised the home visiting policy and developed standardized bereavement resources.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Review autopsy and death scene investigations.				X
2. Present SIDS and safe sleep education programs to health professionals, law enforcement and the public.			X	X
3. Distribute educational materials to hospitals, health providers,				X

and daycare centers.				
4. Collaborate with community-based organizations to disseminate SIDS risk reduction message.			X	
5. Disseminate new American Academy of Pediatrics Safe Sleep Guidelines to healthcare professionals.				X
6. Administer social marketing campaign about safe sleep environment promotion within high-risk areas.			X	
7. Provide grief counseling for families of SIDS/OID victims through agency collaboration.		X	X	
8. Promote regulatory guidelines for safe sleep environment in day care and family day home centers.		X		
9.				
10.				

b. Current Activities

Direct and Enabling

The SIDS Program continues to coordinate with Children's Bureau to provide grief counseling for families of SIDS/OID victims in the New Orleans area.

Population-Based Services

The social marketing public information campaign about safe sleep environment began to focus on accidental suffocation within high-risk target population areas through media, community outreach, and medical profession outreach. Current campaign efforts continue to target racial disparities through media materials and placement to reach low income populations based on formative, qualitative, and market research.

Infrastructure Building Services

The SIDS Program continues to provide technical assistance for development of policy related to safe sleep environment in licensed childcare facilities and provide a template policy to licensed facilities. MCH collaborates with community-based agencies in dissemination of risk reduction messages. The SIDS Program continues provision of training for licensed childcare providers related to safe sleep environment. The Child Health Medical Director continues to review autopsy and death scene investigations. The CDRP continues reviewing all unexpected deaths in children under the age of 15, including all SIDS deaths. The CDRP has collaborated with the SIDS program to implement the revised home visiting policy and protocol. The SIDS program began distributing standardized bereavement resources to all families who experienced a SUID.

c. Plan for the Coming Year

Objective: To reduce to 0.8 per 1,000 live births the number of infant deaths due to Sudden Infant Death Syndrome.

Direct and Enabling Services

Children's Bureau will continue to provide counseling and resources for families who are victims of SIDS/OID (Other Infant Deaths) as needed in the Greater New Orleans area. The OPH will continue to provide bereavement support to SIDS families in the remainder of the state.

Population-Based Services

The social marketing public information campaign with an emphasis on safe sleep environment promotion will continue to be implemented within high-risk target population areas of the state through media, community outreach and medical profession outreach. Qualitative research and evaluation results based on current media material and messaging will be used to develop culturally competent educational materials. Market research will continue to be used to develop new campaign strategies to effectively target hard to reach populations. The SIDS Program will continue to collaborate with MCH Child Safety Coordinators in regional risk reduction activities

such as educational and crib giveaway programs.

Infrastructure Building Services
The SIDS Program will continue interagency collaboration with existing community-based agencies and organizations in promotion of safe sleep environment messages. The SIDS Program will continue to provide technical assistance for development of policy and/or regulatory standards related to safe sleep environment in licensed childcare facilities. The SIDS Program plans to continue provision of training for licensed childcare and family day home providers related to safe sleep environment.

Autopsy and death scene investigations will continue to be reviewed by the Child Health Medical Director. Infant Death Scene Investigation trainings will be revised and continued at the regional level to ensure that coroners, death scene investigators, first responders, and stakeholders possess the necessary skills to respond in a supportive, culturally competent manner to families who have experienced a sudden unexpected death and ensure protocol is followed. The Child Death Review Panel will continue reviewing all SIDS deaths. Special reports on infant mortality will continue to be provided to the State Commission on Perinatal Care and Infant Mortality and other interested groups.

State Performance Measure 9: *Percent of state fetal and infant deaths reviewed by a Feto-Infant Mortality Review (FIMR).*

a. Last Year's Accomplishments
The recent availability of fetal death data, final for 2006 and 2007 and preliminary for 2008, indicates an increasing proportion of fetal and infant deaths have been reviewed by a FIMR each year. The percent of eligible deaths reviewed increased from 11.8% in 2005 to 18.8%, 24.0%, and a preliminary 27.2% in 2006, 2007, and 2008, respectively. These rates exceed the annual performance objectives for 2006, 2007, and 2008, underscoring the work to help identify important issues surrounding these deaths occurring in active FIMR regions. Case Review Teams in the active regions reviewed 225 cases were abstracted at 35 birthing hospitals and reviewed in eight regional FIMR CRTs. However, the percent of deaths reviewed will not be available until 2009 vital records data are made available.

Population-Based Services
Recommendations from the regional FIMR Community Action Teams (CAT) resulted in population-based interventions. Partners for Healthy Babies (PHB) included support for FIMR media outreach, i.e., SIDS campaign in Lake Charles region and coordination of Stork Reality preconception messaging and onsite "Sammy the Stork" presentations with regional FIMRs.

Infrastructure Building Services
In 2001, Louisiana MCH program began the promotion and development of a state-wide FIMR process by supporting regional communities in the development of a standard fetal and infant death review process. This review is an important part of understanding the factors contributing to the deaths in our state, informing the community of the issues, and mobilizing the community to action to prevent these deaths. The reviews began in regions with the strongest infrastructure, systematically expanding to encompass all nine regions in Louisiana. The plan was to focus on the largest parish in each of the nine regions of the state, with each regional team expanding to address additional parishes in the region over time. MCH funds a FIMR coordinator in each of the active regions. The coordinator abstracts and summarizes death charts, conducts a home visit to the mother and presents the cases to the Case Review Team (CRT), and works to organize and maintain the local Community Action Team (CAT).

Regional FIMRs' CRT and CAT members advocate for the needs of mothers and infants, including developing resource lists, involvement in media campaigns for SIDS, SIUDS, substance use, depression, domestic violence, legislative contacts regarding health policy and reform,

minority health events and outreach efforts, and involvement of local government and business leaders. FIMRs conducted CRT meetings and CAT meetings in the eight active regions.

Collaborations continue with organizations to co-fund the salary of the FIMR coordinator in Healthy Start in New Orleans. Family Road of Greater Baton Rouge and Family Tree, each Healthy Start sites, supported the regional FIMR through supplies and administrative support and contracts. Collaboration with regional Office of Public Health (OPH) Medical Directors and Administrators and regional epidemiologists supported the FIMR coordinators. Obstetricians and pediatricians from regional hospitals participated on Case Review Team and functioned as FIMR Medical Directors in the regions. Regional community organizations participated on each FIMR Community Action Team meeting. Over 500 community and provider groups statewide participate in the FIMR program. MCH state Needs Assessment protocol developed and included FIMR CRT and CAT participation for Fall 2009. An electronic FIMR reporting system, Basinet, is being utilized.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Support and assist regional FIMR Case Review Teams (CRT).				X
2. Support FIMR CRT expansion into additional hospitals.				X
3. Help facilitate identification of deaths for FIMR review through vital records system.				X
4. Provide Technical Assistance to FIMR coordinators.				X
5. Present state and regional epidemiologic data to FIMRs.				X
6. Support FIMR forums and Community Action Teams.				X
7. Assist regional FIMR community teams with intervention ideas and/or implementation of activities to improve outcomes.			X	X
8. Coordinate FIMR and Injury Prevention activities.				X
9. Provide regional Needs Assessment Evaluation Plans.				X
10. Develop statewide programs for regional implementation.				X

b. Current Activities

Population-Based Services

FIMRs participate with regional Red Cross and other groups in disaster planning for pregnant and breastfeeding women and infants. PHB helpline continues as resource for FIMR groups and individuals statewide.

Infrastructure Building Services

Work continues with state Vital Records on the timely provision of death certificate information to FIMR Coordinators. A FIMR coordinator hired in the 9th DHH region, was instrumental in organizing a stakeholder group for the MCH 2010 Needs Assessment and is currently abstracting records at two hospitals and has organized a CRT and community partners. In the Monroe region, the grant renewed providing for additional FIMR nurse abstractor and coordinator and expansion in the area. FIMR nurses trained in bereavement conducted local hospital coordinated seminars. Regional CATs include members of faith-based, hospitals, social service agencies, March of Dimes, tobacco programs, public health staff. The Baton Rouge FIMR presented at all area Rotary Clubs and involve their members in the CAT. The Lafayette region has been instrumental in promoting regional breastfeeding and has a faith based coalition. Southwest Louisiana FIMR has been active with SIDS and SIUDS initiatives and is often on regional television programs. Central Louisiana FIMR collaborated with Bureau of Minority Health Access to provide health fairs in a rural underserved parish and health ministry trainings for 15 faith groups.

c. Plan for the Coming Year
Objective: Increase the percentage of fetal and infant deaths reviewed by a FIMR to 30%

Population-Based Services
Recommendations from the regional FIMR CATs and forums continue to result in population-based interventions including expanding resource directories to include services for substance use, domestic violence, and depression. FIMR will coordinate activities with Injury Prevention Program and Breastfeeding Coalitions. The Partners for Healthy Babies program works with FIMR coordinators in educational efforts.

Infrastructure Building Services
All nine regions of the state will be active in FIMR reviews. While work with Vital Records has allowed access to death certificates, the timeliness of this process will improve with projected vital records programming. Regional FIMRs will continue to review cases and support community interventions. Opportunity for community action will be carried out through FIMR community groups and regional forums. The FIMR review teams regularly provide recommendations to the established Community Action Teams. These Community Teams continue to support measures to address circumstances surrounding fetal and infant deaths at the community level throughout Louisiana. The Screening, Brief Intervention, Referral and Treatment for substance use, domestic violence and depression (SBIRT)-Healthy Babies Initiative (HBI) will expand to all regions of the state, and include WIC clinics. FIMR groups are working closely with regional SBIRT-HBI coordinators to identify needs, community resources, and provide education through CRT/CAT meetings.

Regional FIMR groups collaborate for emergency plans for MCH populations, especially pregnant women, new mothers, and infants and coordinate with regional Red Cross and Public Health offices. FIMR groups will be an integral part of the MCH Inter-conception initiative, recently funded through DHH. Needs Assessment results will be presented to regional FIMRs and will provide regional as well as statewide directives for MCH issues.

Targeted educational activities to regional providers and stakeholders will help encourage regional action to address prematurity and VLBW births. Continued use of the online, electronic reporting system, Basinet, will occur, with data aggregation of cases reviewed.

State Performance Measure 11: *Percent of Louisiana resident women giving birth who undergo screening for substance use, depression, and domestic violence using the SBIRT-HBE approved methods.*

a. Last Year's Accomplishments
There were 10.3% (6,670 pregnant women) of 65,063 deliveries screened using the SBIRT Program in 2009, which was an increase from 6.4%, 4,271screened of 66,686 deliveries in 2008.

Direct and Enabling Services
MCH, partnering with Office of Addictive Disorders, developed the SBIRT program for statewide use through the 4Ps Plus risk assessment program and tool developed by Dr. Ira Chasnoff for substance abuse, perinatal depression, and domestic violence during pregnancy. This risk assessment is administered to pregnant women at their obstetrician's offices and Office of Public Health WIC sites, thereby providing opportunity for earlier establishment of risk factors for pregnancy and child outcomes, and providing an opportunity for earlier intervention. Six of the state's 9 regions had coordinators and were actively screening.

From initiation of the Baton Rouge project in May 2005 and adding sites May 2007 through CY

12/31/09, the SBIRT program in the six regions screened 18,874 pregnant women. In CY 2009, Screening in WIC sites (n=4117) identified 17.8% of women using tobacco cigarettes, 4.7% used alcohol, 1.8% used marijuana, 0.1% used drugs since they knew they were pregnant, 7.1% identified at risk for domestic violence and 16.4% identified at risk for depression. Obstetrical provider sites in CY2009 (n=2553) indicated that 20.9% used tobacco cigarettes, 7.8% used alcohol, 3.0% used marijuana, 0.8% used drugs since they knew they were pregnant. Cumulative data 05/01/05-12/31/09 indicated that 23.6% of pregnant women screened in non-WIC sites and 31.4% in WIC sites accepted the Brief Intervention. All women screened receive the information that "no amount of tobacco or alcohol is safe in pregnancy." Referral directories were updated in each region by SBIRT and FIMR coordinator collaboration and are given to providers and patients.

Infrastructure Building Services
MCH with its other SBIRT-HBI partners continued to urge adoption of the screening tool by all providers within the state, public and private. Private providers continued to receive technical support and screening result data. The work with MCH Epidemiology staff to begin data analysis of pregnancy outcomes on women with intervention and treatment from the program continued.

Substance abuse services continued to be identified as a priority need. The Fetal Infant Mortality Reduction Initiative (FIMR) focused on factors contributing to high infant mortality and prematurity rates. Alcohol and substance use is a significant contribution to these rates. Regional Feto-Infant Mortality Reviews (FIMRs) are looking at problems and solutions at the local level. The MCH Maternity Medical Director and Nurse Consultant continued visits to OB Medicaid providers and birthing hospitals, providing education and resources. Discussion continued with Louisiana Medicaid to make SBIRT screening a pay for performance initiative for providers. State SBIRT Director presented programs on effects of maternal alcohol use during pregnancy. Regional Technical Assistance and community information sessions continued being given by State Director and regional coordinators. All state WIC RN and nutritionists received training by Dr. Ira Chasnoff in January 2009.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Expand SBIRT-HBI activities in all regions of the state.	X	X	X	X
2. Perform SBIRT- HBI screening in WIC clinics.	X			
3. Update resource manuals for SBIRT-HBI referrals for treatment.				X
4. Assist to identify service shortages (especially substance abuse, depression, domestic violence treatment) and promote expansion of services for pregnant women.			X	X
5. Translate the SBIRT Screening tool in to Spanish.			X	
6. Work with Medicaid to provide reimbursement for SBIRT-HBI activities.				X
7.				
8.				
9.				
10.				

b. Current Activities
Direct and Enabling Services
SBIRT-HBI expanded to a total of 8 regions. Plans are in place to expand services to all 9 regions of the state in 2010. Referral directories are updated quarterly in each region of the state and as needed. Discussion continues for Medicaid to reimburse for screening and brief

intervention services. Nurse Family Partnership (NFP) continues to address alcohol and substance use in pregnancy in all areas of the state.

Discussions are underway with the state Office of Mental Health (OMH) to increase access to mental health services for those who screen positive and need further evaluation / treatment. State Office of Addictive Disorders (OAD) continues to offer priority treatment to pregnant women. Referral directories previously developed are being updated as needed.

Infrastructure Building Services
MCH Needs Assessment process in Fall 2009 identified risk of substance use, domestic violence and depression as priority needs. Needs assessment conducted through regional FIMR and SBIRT teams identified these as barriers to healthy babies and good birth outcomes. MCH strategic planning to involve regional FIMR/SBIRT teams in inter-conception and preconception planned projects. MCH team epidemiology evaluation begun in collaboration with Childrens Research Triangle Chicago.

c. Plan for the Coming Year
Objective: Increase the number of pregnant women screened by SBIRT-HBI to 15%.

Direct and Enabling Services
The SBIRT-HBI program will expand statewide and be utilized in WIC clinics statewide. This tool is being provided to all obstetrical providers, and could potentially screen every pregnant woman in the state for alcohol use. Use of the tool in Family Planning clinics is planned. DHH-Tobacco Control Program Fax-to-Quit will continue to be an integral part of SBIRT and training will commence statewide for private and public providers. Each region will have SBIRT-HBI coordinators. Health units providing prenatal care will continue to screen for alcohol and offer brief intervention and referral for cessation services.

The NFP home visiting program will continue to address substance abuse during pregnancy, providing education, counseling and referrals for women in need of these services in all regions of the state.

Population-Based Services
Partners for Healthy Babies public information campaign will continue the promotion of healthy pregnancy campaigns, with prevention of alcohol / substance use in pregnancy as a part of that message. Media expansion is planned through collaboration with DHH Tobacco Control Program grant for pregnant women on cessation activities.

Infrastructure Building Services
The SBIRT-HBI will continue to build local support for screening, intervention, treatment, and prevention of alcohol / substance use in pregnancy. All regions of the state will have activities. Legislative efforts to criminalize pregnant women who use substances are being countered by attempts to expand screening and access to treatment.

State MCH is continuing to work with Regional MCH FIMR/SBIRT teams to promote inter-conception and preconception programs to decrease substance use, domestic violence and depression, all of which impact birth outcomes. MCH will continue to meet with Medicaid to promote efforts to enhance quality of care issues. Discussions will continue with Medicaid to reimburse and implementation a pay-for-performance using the SBIRT screening / intervention.

E. Health Status Indicators

Introduction
Health Status Indicators are an evaluative measure that can be used to compare the state's death rates to past rates and to other states' rates. MCH can assess the achievement of efforts, appropriateness of efforts, and effectiveness of preventive interventions and allocated resources over time. Death rates are just one of several measures of our state's health status. Awareness of the leading causes of death can more efficiently and effectively target our efforts and resources toward building a healthier and safer community. HSI serves as a surveillance or monitoring tool to identify the causes of death, risk factors, and the "at risk" groups based on age, race, and ethnicity and to plan preventive interventions. The state can enhance data capacity through the improvement of existing data linkages and the establishment of new data linkages and surveillance systems. Current linkages between the birth files, infant death files, Medicaid eligibility files, WIC files, and newborn screening data will continue to allow in depth analyses and evaluation by the MCH and CSHCN Programs, which identify priority needs for programs and interventions.

Health Status Indicators 01A: *The percent of live births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	11.5	11.4	11.3	11.2	11.2
Numerator	6821	7226	7447	7292	7292
Denominator	59442	63184	66062	65089	65089
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
2009 data is provisional and is based upon 2008 data.

Notes - 2008
2008 data is preliminary.

Notes - 2007
2007 data is final.

Narrative:
Preliminary 2008 data indicate that 11.2% of Louisiana infants weighed less than 2,500 grams at delivery. The rate has slowly decreased by 0.1 percentage points each year since 2005, when the rate was 11.5%.

Low birth weight can provide valuable information as a general indicator of the state's maternal health status and prenatal care provision. While a surrogate marker for prematurity, it can also identify infants who have intrauterine growth restriction. By analyzing low birth weight infants by regions, patient characteristics, and specific population groups such as payer type, it can help direct resources to those areas in most need. By following this figure over time, one can obtain a general measure of risks and results of interventions.
Specific interventions include the Infant Mortality Reduction Initiative, smoking cessation program, dental services program, substance abuse and depression screening programs.

Louisiana has a family planning waiver, Take Charge, to assist service access for Medicaid eligible women post-delivery. MCH provided enhanced preconception services, especially folic acid use, to the family planning program. The SBIRT program is providing screening / intervention services for substance abuse, depression and domestic violence. The SBIRT program is statewide, in private and public prenatal clinics, and is being expanded to all OPH-WIC clinics statewide. An expanded focus on preconceptional and interconceptional health services is occurring, especially in regard to prevention of adverse pregnancy outcomes. Plans are being developed to identify those women with VLBW and LBW and provide enhanced case management and/or referrals to Healthy Starts (4 in Louisiana), to Family Planning and community care facilities, and to refer Medicaid eligible first time pregnant women to Nurse Family Partnership, nurse home visiting program that follows the woman through the child's 2nd birthday.

Data sharing agreements are ongoing with key partners of the MCH program. Data linkages of vital records birth. infant death, and fetal death files with Louisiana Medicaid eligibility, Women, Infants, and Children (WIC) eligibility files, Hospital Inpatient Discharge, newborn screening, Louisiana Pregnancy Risk Assessment Monitoring System (PRAMS), Louisiana Birth Defects, and the Caring Communities in Youth Survey data are ongoing to increase data capacity, analyses, and dissemination of program relevant information.

Health Status Indicators 01B: *The percent of live singleton births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	9.5	9.5	9.3	9.3	9.3
Numerator	5461	5775	5931	5858	5858
Denominator	57476	61068	63775	62900	62900
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
2009 data is provisional and is based upon 2008 data.

Notes - 2008
2008 data is provisional.

Notes - 2007
2007 data is final.

Narrative:
The percent of singleton live births weighing less than 2,500 grams at delivery was 9.3% in both 2007 and 2008. This represents a decrease from the 9.5% seen in 2005 and 2006 but an increase from 9.1% noted in 2004.

Low birth weight can provide valuable information as a general indicator of the state's maternal health status and prenatal care provision. While a surrogate marker for prematurity, it can also

identify infants who have intrauterine growth restriction. Multiple gestations have much higher rates of low birth weight deliveries. By following the percent of low birth weight in singleton births, it allows a better analysis of prenatal systems of care, maternal risks, and the effectiveness of treatments. By following this figure over time, one can obtain a general measure of risks and results of interventions.

Specific interventions include the Infant Mortality Reduction Initiative, smoking cessation program, dental services program, substance abuse and depression screening programs.

Louisiana has a family planning waiver, Take Charge, to assist service access for Medicaid eligible women post-delivery. MCH provided enhanced preconception services, especially folic acid use, to the family planning program. The SBIRT program is providing screening / intervention services for substance abuse, depression and domestic violence. The SBIRT program is statewide, in private and public prenatal clinics, and is being expanded to all OPH-WIC clinics statewide. An expanded focus on preconceptional and interconceptional health services is occurring, especially in regard to prevention of adverse pregnancy outcomes. Plans are being developed to identify those women with VLBW and LBW and provide enhanced case management and/or referrals to Healthy Starts (4 in Louisiana), to Family Planning and community care facilities, and to refer Medicaid eligible first time pregnant women to Nurse Family Partnership, nurse home visiting program that follows the woman through the child's 2nd birthday.
Enhanced data capacity arises through the improvement of existing data linkages and the establishment of new linkages and surveillance systems. Data linkages of vital records birth, infant death, and fetal death files with Louisiana Medicaid eligibility, Women, Infants, and Children (WIC) eligibility files, Hospital Inpatient Discharge, newborn screening, Louisiana Pregnancy Risk Assessment Monitoring System (PRAMS), Louisiana Birth Defects, and the Caring Communities in Youth Survey data are ongoing to increase data capacity, analyses, and dissemination of program relevant information to MCH and CSHCN Program staff, who identify priority needs and targeted interventions.

Health Status Indicators 02A: *The percent of live births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	2.3	2.2	2.2	2.6	2.6
Numerator	1353	1380	1458	1677	1677
Denominator	59442	63184	66062	65089	65089
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
2009 data is provisional and is based upon 2008 data.

Notes - 2008
2008 data is provisional.

Notes - 2007
2007 data is final.

Narrative:

The preliminary data for 2008 indicate that 2.6% of all Louisiana infants were born weighing less than 1,500 grams, a substantial increase over the 2.2% noted in 2006 and 2007.

Very low birth weight can provide valuable information as a general indicator of the state's maternal health status and prenatal care provision. While a surrogate marker for prematurity, it can also identify infants who have extreme intrauterine growth restriction. By analyzing very low birth weight infants by regions, patient characteristics, and specific population groups such as payer type, it can help direct resources to those areas in most need. By following this figure over time, one can obtain a general measure of risks and results of interventions.

Specific interventions include the Infant Mortality Reduction Initiative, smoking cessation program, dental services program, substance abuse and depression screening programs.

Louisiana'sTake Charge family planning waiver has been found to be underutilized due to limitations in scope of coverage. Folic acid is provided in state family planning clinics. An expanded focus on preconceptional and interconceptional health services is occurring, especially in regard to prevention of adverse pregnancy outcomes. The SBIRT program screening and making referrals for substance use, depression and domestic violence in pregnant women is statewide, and in selected WIC clinics.

As with other priority measures and indicators, ongoing availability of data and linkages between data sources will enable enhanced data capacity, analyses, and dissemination of program relevant information. These data are routinely used to monitor trends over time, such as the increased noted for 2008. When final 2008 data become available, an investigation can begin into factors that may have contributed to this increase.

Health Status Indicators 02B: *The percent of live singleton births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	1.8	1.7	1.8	2.1	2.1
Numerator	1047	1063	1145	1342	1342
Denominator	57476	61068	63775	62900	62900
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
2009 data is provisional and is based upon 2008 data.

Notes - 2008
2008 data is provisional.

Notes - 2007
2007 data is final.

Narrative:
In 2008, the percent of singleton live births weighing less than 1,500 grams was 2.1%. This represents an increase from 1.8% in 2007 and 1.7% in 2006.

Very low birth weight can provide valuable information as a general indicator of the state's maternal health status and prenatal care provision. While a surrogate marker for prematurity, it can also identify infants who have extreme intrauterine growth restriction. Multiple gestations have much higher rates of very low birth weight deliveries. By following the percent of very low birth weight in singleton births, it allows a better analysis of prenatal systems of care, maternal risks, and the effectiveness of treatments. By following this figure over time, one can obtain a general measure of risks and results of interventions. Specific interventions include the Infant Mortality Reduction Initiative, smoking cessation program, dental services program, substance abuse and depression screening programs.

Louisiana'sTake Charge family planning waiver has been found to be underutilized due to limitations in scope of coverage. Folic acid is provided in state family planning clinics. An expanded focus on preconceptional and interconceptional health services is occurring, especially in regard to prevention of adverse pregnancy outcomes. The SBIRT program screening and making referrals for substance use, depression and domestic violence in pregnant women is statewide, and in selected WIC clinics.

Ongoing availability of data and linkages between data sources enable enhanced data capacity, analyses, and translation. These data are required to investigate factors that may be contributing to the increased rate noted in 2008. Upon completion of analyses, results can be used to further guide program resources and interventions, completing one of the steps in the data to action link.

Health Status Indicators 03A: *The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	12.2	13.0	12.9	16.3	16.3
Numerator	115	117	115	149	149
Denominator	946320	897508	888587	914724	914724
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
2009 data is provisional and is based upon 2008 data.

Notes - 2008
2008 data is provisional.

Notes - 2007
2007 data is final.

Narrative:
In 2007, the final death rate per 100,000 due to unintentional injuries among children under 15 years was 12.9 per 100,000, which is unchanged from the 2006 rate of 13.0 per 100,000. The death rates have remained stable from 2005 (12.2 per 100,000) to 2006 (13.0 per 100,000) to 2007 (12.9 per 100,000). Final 2008 data is pending.

Unintentional injury fatalities are preventable. Louisiana's data shows that unintentional injuries are the leading causes of mortality among children ages 1 month through 14 years, primarily due to motor vehicle crashes, accidental suffocation, exposure to smoke/fire, and accidental drowning/submersion. Unintentional injury mortality surveillance is a mechanism to measure preventable deaths and identify causes, high risk groups, and risk factors. Surveillance data is necessary for needs assessments, resource allocation, program planning, policy development, legislative action, and for mobilizing communities to implement effective prevention interventions which target behaviors that endanger children.

Unintentional injury fatality data of children under age 15 years serves as a measure to evaluate the effectiveness of MCH-supported child safety/injury prevention efforts of the MCH Regional Child Safety Coordinators, for child passenger safety, pedestrian safety, fire and water safety, home and outdoor safety; SIDS Risk Reduction and Safe Sleep Program, infant safe sleep environments; Child Care Health Consultant Program and healthy and safe child care environments; School-Based Health Centers and healthy and safe school environments; Parish Health Units and injury prevention education; and State and Local Child Death Review Panels and case reviews and preventive intervention recommendations.

Health Status Indicators 03B: *The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	4.4	4.8	5.7	5.0	5.0
Numerator	42	43	51	46	46
Denominator	946320	897508	888587	914724	914724
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
2009 data is provisional and is based upon 2008 data.

Notes - 2008
2008 data is provisional.

Notes - 2007
2007 data is final.

Narrative:
According to Louisiana 2007 data, more children under 15 years of age died from unintentional injuries due to motor vehicle crashes in 2007 at a rate of 5.7 per 100,000 than in 2006 (4.8 per 100,000) and in 2005 (4.4 per 100,000). However, provisional 2008 data suggests a decrease in the death rate to 5.0 per 100,000.

Louisiana data shows that motor vehicle crashes are the leading causes of unintentional injury fatalities among children under 15 years of age. Most deaths due to motor vehicle crashes are preventable, and the most effective ways to reduce these deaths are to use seat belts and to properly restrain child passengers in moving motor vehicles. Injury mortality surveillance is a mechanism to measure preventable motor vehicle-related deaths and identify causes, high risk groups, and risk factors. Motor vehicle-related surveillance data is necessary for needs assessments, resource allocation, program planning, policy development, legislative action, and for mobilizing communities to implement effective preventive interventions which target behaviors that endanger children.

Motor vehicle-related fatality data of children serve as measures to evaluate the effectiveness of MCH-supported child safety outreach and education efforts of the MCH Regional Child Safety Coordinators as Nationally Certified Child Passenger Safety Technicians, for child passenger safety, pedestrian safety, ATV safety, back (roll) over prevention, bicycle safety, and installation education of infant car seats and child booster seats; Child Care Health Consultant Program, for safe transportation trainings in child care environments; School Base Health Centers, for safe transportation of students and safe teen driving; Parish Health Units, for family outreach and education on child passenger safety; and State and Local Child Death Review Panels, for case reviews and preventive intervention recommendations.

Health Status Indicators 03C: *The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	28.5	34.4	36.1	32.4	32.4
Numerator	199	223	237	215	215
Denominator	699069	647755	657229	664524	664524
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
2009 data is provisional and is based upon 2008 data.

Notes - 2008
2008 data is provisional.

Notes - 2007
2007 data is final.

Narrative:
According to 2007 Louisiana mortality data, more teens and young adults ages 15 through 24 years died from unintentional injuries due to motor vehicle crashes, at a rate of 36.1 per 100,000 than in 2006 (34.4 per 100,000), and 2005 (28.5 per 100,000). However, provisional 2008 data shows a rate of 32.4 per 100,000, which is lower than the 2006 and 2007 rates.

Motor vehicle crashes (MVCs) are the most common preventable causes of unintentional injury fatalities in this age group. The most effective way to reduce deaths from MVCs in this age group is to wear seat belts. Injury surveillance of deaths due to motor vehicle crashes can identify behavioral risk factors and high risk groups, and the data is necessary for needs assessments, resource allocations for injury prevention, program planning, policy development, legislative action, and for mobilizing communities to implement effective preventive interventions which target behaviors that endanger teens and young adults.

Fatality data of motor vehicle crashes for teens and young adults is used to assess the resource allocations for and the effectiveness of collaborative injury prevention outreach and educational efforts of the MCH Child Safety Coordinators as National Child Passenger Safety Technicians with Louisiana Passenger Safety Task Force, the state Injury Research and Prevention Program, School-Based Health Centers, and Public Health Units on passenger safety/seat belt usage, distracted driving risks, pedestrian safety, bike safety/helmet usage, and ATV safety.

Health Status Indicators 04A: *The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	219.1	265.4	158.6	158.6	158.6
Numerator	2101	2382	1409	1409	1409
Denominator	958711	897508	888587	888587	888587
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
Data is provisional, based upon 2007 data. However, since 2002, improved methods for injury data collection have been implemented. Data is based upon nonfatal hospitalized injuries.

Notes - 2008
Data is provisional, based upon 2007 data. However, since 2002, improved methods for injury data collection have been implemented. Data is based upon nonfatal hospitalized injuries.

Notes - 2007
Data is final. However, since 2002, improved methods for injury data collection have been implemented. Data is based upon nonfatal hospitalized injuries.

Narrative:
According to Louisiana 2007 data, there were less non-fatal injuries among children aged 14 years and younger at a rate of 158.6 per 100,000 than in 2006 (265.4 per 100,000) and 2005 (219.1 per 100,000). Final 2008 data is pending.

Louisiana's injury data surveillance shows that injuries are the leading causes of morbidity and mortality of children aged 14 years and younger. Falls are the leading causes of non-fatal injuries for this age group in Louisiana, and most injuries are preventable. Therefore, injury surveillance can identify behavioral risk factors and high risk groups; serve as a starting point for community assessment of needs; and measure preventable injuries. Community advocates and policy makers can use information from injury surveillance to create a safe community by prioritizing and planning preventive interventions and by informing community and legislative action which targets behaviors that endanger children.

Injury surveillance data of children under age 15 years serves as a measure to evaluate the effectiveness of and resource allocations for MCH-supported child safety/injury prevention efforts of the MCH Regional Child Safety Coordinators, for falls prevention, child passenger safety, pedestrian safety, fire and water safety, home and outdoor safety; SIDS Risk Reduction and Safe Sleep Program, for infant safe sleep environments; Child Care Health Consultant Program, for healthy and safe child care environments; School- Based Health Centers, for healthy and safe school environments; Parish Health Units, for injury prevention education; and State and Local Child Death Review Panels, for case reviews and preventive interventions recommendations.

Health Status Indicators 04B: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	42.5	19.2	39.7	39.7	39.7
Numerator	407	172	353	353	353
Denominator	958711	897508	888587	888587	888587
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
Data is provisonal and based upon the 2007 data.

Notes - 2008
Data is provisional, based upon 2007 data.

Notes - 2007
Data is final.

Narrative:

According to Louisiana 2007 data, the rate per 100,000 of non-fatal injuries due to motor vehicle crashes among children aged 14 years and younger is 39.7 per 100,000, which is less than the rate of 42.5 per 100,000 in 2005. Because there were many missing e-codes in the data in 2006 and because only 172 non-fatal injuries had motor vehicle-related e-codes for this age group, the 2006 rate was very low at 19.2 per 100,000.

Motor vehicle crashes (MVCs) are one of the most common and preventable causes of non-fatal injuries in this age group. The most effective ways to reduce injuries from MVCs are to wear seat belts and to properly restrain child passengers. Injury surveillance is a mechanism to measure preventable motor vehicle-related injuries and identify causes, high risk groups, and risk factors. Motor vehicle-related surveillance data is necessary for needs assessments, resource allocation, program planning, policy development, legislative action, and for mobilizing communities to implement effective prevention interventions which target behaviors that endanger children.

Motor vehicle-related fatality data of children serve as measures to evaluate the effectiveness of MCH-supported child safety outreach and education efforts of the MCH Regional Child Safety Coordinators as Nationally Certified Child Passenger Safety Technicians, for child passenger safety, pedestrian safety, ATV safety, back (roll) over prevention, bicycle safety, and installation education of infant car seats and child booster seats; Child Care Health Consultant Program, for safe transportation trainings in child care environments; School Base Health Centers, for safe transportation of students and safe teen driving; Parish Health Units, for family outreach and education on child passenger safety; and State and Local Child Death Review Panels, for case reviews and preventive interventions recommendations.

Health Status Indicators 04C: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	139.2	85.2	137.7	137.7	137.7
Numerator	980	552	905	905	905
Denominator	704198	647755	657229	657229	657229
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009

Data is provisional, and based on 2007. Since 2002, the primary data source of analysis and reporting for this indicator is the Louisiana Hospital Inpatient Discharge Data (LAHIDD). LAHIDD is compiled by the Health Statistics Department of the Louisiana Office of Public Health, and EMS/Injury Research and Prevention Program analyzes the data needed for this indicator. Since participation in reporting hospital inpatient discharge data is not mandatory in Louisiana, then differences in the number, size, and type of hospitals reporting annually will affect our data reported. This variability limits year-to-year comparison analyses.

Notes - 2008

Data is provisional, and based on 2007. Since 2002, the primary data source of analysis and reporting for this indicator is the Louisiana Hospital Inpatient Discharge Data (LAHIDD). LAHIDD is compiled by the Health Statistics Department of the Louisiana Office of Public Health, and EMS/Injury Research and Prevention Program analyzes the data needed for this indicator. Since participation in reporting hospital inpatient discharge data is not mandatory in Louisiana, then differences in the number, size, and type of hospitals reporting annually will affect our data reported. This variability limits year-to-year comparison analyses.

Notes - 2007
Data is final. Since 2002, the primary data source of analysis and reporting for this indicator is the Louisiana Hospital Inpatient Discharge Data (LAHIDD). LAHIDD is compiled by the Health Statistics Department of the Louisiana Office of Public Health, and EMS/Injury Research and Prevention Program analyzes the data needed for this indicator. Since participation in reporting hospital inpatient discharge data is not mandatory in Louisiana, then differences in the number, size, and type of hospitals reporting annually will affect our data reported. This variability limits year-to-year comparison analyses.

Narrative:
According to Louisiana 2007 data, the rate per 100,000 of non-fatal injuries due to motor vehicle crashes among youth and young adults aged 15-24 years is 137.7 per 100,000, which is less than the rate of 139.2 per 100,000 in 2005. Because there were many missing e-codes in the data in 2006 and because only 552 non-fatal injuries had motor vehicle-related e-codes for this age group, the 2006 rate was very low at 85.2 per 100,000.

Motor vehicle crashes (MVCs) is one of the most common preventable causes of injuries in this age group. The most effective way to reduce injuries from MVCs is to wear seat belts. Injury surveillance is a mechanism to measure preventable motor vehicle-related injuries and identify causes, high risk groups, and risk factors. Motor vehicle-related surveillance data is necessary for needs assessments, resource allocation, program planning, policy development, legislative action, and for mobilizing communities to implement effective preventive interventions which target behaviors that endanger youth and young adults.

Injury surveillance data of children under age 15 years serves as a measure to evaluate the effectiveness of and resource allocations for such MCH-supported child safety/injury prevention efforts of the MCH Regional Child Safety Coordinators, for falls prevention, child passenger safety, pedestrian safety, fire and water safety, home and outdoor safety; SIDS Risk Reduction and Safe Sleep Program, for infant safe sleep environments; Child Care Health Consultant Program, for healthy and safe child care environments; School- Based Health Centers, for healthy and safe school environments; Parish Health Units, for injury preventive education; and State and Local Child Death Review Panels, for case reviews and prevention interventions recommendations.

Health Status Indicators 05A: *The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	29.6	35.2	37.7	42.7	45.0
Numerator	4981	5741	6147	6960	7189
Denominator	168289	162944	162944	162944	159611
Check this box if you cannot report the numerator because					

1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
Data is provisional.

Notes - 2008
The population source is from the 2008 population estimate from U.S. Census Bureau.

Notes - 2007
The population source is from the 2008 population estimate from U.S. Census Bureau.

Narrative:
In 2009, the rate per 1,000 women aged 15-19 years with a reported case of chlamydia was 45.04, up from the 2008 rate of 42.71.

Public health efforts to lower this rate include the continued implementation of sexually transmitted diseases (STD) screening best practices for school-based health centers (SBHCs) throughout the state and incorporation of STD screening as part of the continuous quality improvement initiative of the Adolescent School Health Program (ASHP). In 2009-2010, ASHP required SBHCs to provide onsite STD screening and treatment for students in middle school (5th -- 8th grades) who are sexually active and/or symptomatic, expanding its previous requirement to screen and treat students in 9th grade and higher.

The Office of Public Health Family Planning and STD programs routinely screen for Chlamydia in public health clinics. In April of 2008, the Office of Public Health Laboratory changed to amplified technology for Chlamydia. This new technology allows for a non-invasive collection method that is more sensitive than the previous technology.

This Health Status Indicator serves as a monitoring tool and evaluative measure that will help Louisiana focus its resources on continued efforts to bring down the infection rates. By reducing the proportion of adolescents and young adults with Chlamydia Trachomatitis infections, Louisiana can prevent the resulting complications of this infection.

Public health efforts to lower this rate include the routine screening in Family Planning and STD clinics. The STD Program includes Chlamydia screening as a routine part of patient care for all women attending a STD clinic. The Family Planning Program guidelines call for routine screening of women thirty and younger and women over thirty who are symptomatic or at increased risk for infection.

Health Status Indicators 05B: *The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	9.5	10.6	12.1	13.8	17.2
Numerator	7685	8723	9162	10466	13267
Denominator	811918	825380	757929	757929	771150
Check this box if you cannot report the					

numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
Data is provisional.

Notes - 2008
The population source is from the 2008 population estimate from U.S. Census Bureau.

Notes - 2007
The population source is from the 2008 population estimate from U.S. Census Bureau.

Narrative:
In 2009, the rate per 1000 women age 20 through 44 with a reported case of Chlamydia was 17.2, up from the 2008 rate per 1000 of 13.8.

The Adolescent School Health Program (ASHP) serves students through age 21 if they are still in school. Through ASHP's School-Based Health Centers (SBHC), women age 20 and 21 who are sexually active receive onsite screening and treatment for sexually transmitted diseases (STD).

Public health efforts to lower this rate include the routine screening in Family Planning and STD clinics. The STD Program includes Chlamydia screening as a routine part of patient care for all women attending a STD clinic. The Family Planning Program guidelines call for routine screening of women thirty and younger, and women over thirty who are symptomatic or at increased risk for infection. In April of 2008, the Office of Public Health Laboratory changed to amplified technology for Chlamydia. This new technology allows for a non-invasive collection method that is more sensitive than the previous technology.

This Health Status Indicator serves as a monitoring tool and evaluative measure that will help Louisiana focus its resources on continued efforts to bring down the infection rates. By reducing the proportion of adults with Chlamydia Trachomatitis infections, Louisiana can prevent the resulting complications of this infection.

Health Status Indicators 06A: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race. (Demographics)*

HSI #06A - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	63875	36566	24330	489	946	34	1510	0
Children 1 through 4	246841	141874	92296	1897	3671	141	6962	0
Children 5 through 9	304629	176098	114698	2124	4434	179	7096	0
Children 10 through 14	299379	173325	114962	1904	4399	136	4653	0
Children 15	328634	189431	128638	2288	4423	127	3727	0

through 19								
Children 20 through 24	335890	201818	123543	2244	4930	130	3225	0
Children 0 through 24	1579248	919112	598467	10946	22803	747	27173	0

Notes - 2011
Louisiana Vital Records preliminary 2008 data.

Louisiana Vital Records preliminary 2008 data.

Louisiana Vital Records preliminary 2008 data.

Louisiana Vital Records preliminary 2008 data.

Louisiana Vital Records preliminary 2008 data.

Louisiana Vital Records preliminary 2008 data.

Narrative:
Please refer to data in FORM 21.

This measure provides information on the state's residents because it provides Public Health risk and health information based upon these factors.

The indicator provides guidance for age-specific programs such as immunization, family planning, school based health and maternity care. In 2008, for infants 0-1, 38% were African American. This data informs and directs social marketing campaigns that address the disparities in this population with higher rates of prematurity, low birth weight and Sudden Infant Death Syndrome (SIDS).

In 2008, the Hispanic/Latino population remains at 4% of the population for all ages of infants and children 0-24 years, as in 2007. This indicator merits future monitoring of a shift in this population, a shift that would dictate new tools and methods of maternal and child health care. Louisiana continues to monitor its shift in the Hispanic population. Many community education programs, particularly in New Orleans, are now developing print materials in Spanish and English.

MCH will continue to monitor the demographics of our children in order to evaluate the best provision for appropriate levels of service.

Health Status Indicators 06B: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and Hispanic ethnicity. (Demographics)*

HSI #06B - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	61282	2593	0
Children 1 through 4	234662	12179	0
Children 5 through 9	291435	13194	0
Children 10 through 14	288251	11128	0
Children 15 through 19	318038	10596	0

Children 20 through 24	323846	12044	0
Children 0 through 24	1517514	61734	0

Notes - 2011
Louisiana Vital Records preliminary 2008 data.

Louisiana Vital Records preliminary 2008 data.

Louisiana Vital Records preliminary 2008 data..

Louisiana Vital Records preliminary 2008 data.

Louisiana Vital Records preliminary 2008 data.

Louisiana Vital Records preliminary 2008 data.

Narrative:
Please refer to data in FORM 21.

This measure provides information on the state's residents because it provides Public Health risk and health information based upon these factors.

The indicator provides guidance for age-specific programs such as immunization, family planning, school based health and maternity care. In 2008, for infants 0-1, 38% were African American. This data informs and directs social marketing campaigns that address the disparities in this population with higher rates of prematurity, low birth weight and Sudden Infant Death Syndrome (SIDS).

In 2008, the Hispanic/Latino population remains at 4% of the population for all ages of infants and children 0-24 years, as in 2007. This indicator merits future monitoring of a shift in this population, a shift that would dictate new tools and methods of maternal and child health care. Louisiana continues to monitor its shift in the Hispanic population. Many community education programs, particularly in New Orleans, are now developing print materials in Spanish and English.

MCH will continue to monitor the demographics of our children in order to evaluate the best provision for appropriate levels of service.

Health Status Indicators 07A: *Live births to women (of all ages) enumerated by maternal age and race. (Demographics)*

HSI #07A - Demographics (Total live births)

CATEGORY Total live births	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Women < 15	137	26	108	3	0	0	0	0
Women 15 through 17	2585	938	1575	17	14	0	41	0
Women 18 through 19	6186	2793	3240	59	26	0	68	0
Women 20	50461	29237	19141	359	852	7	865	0

through 34								
Women 35 or older	5721	3812	1534	37	227	1	110	0
Women of all ages	65090	36806	25598	475	1119	8	1084	0

Notes - 2011

Narrative:
Please refer to data in FORM 21.

This measure provides information on the state's residents because it provides pregnancy information based upon these factors.

This measure provides guidance for age specific programs such as prenatal care, family planning, and direction of resources to the under or uninsured.

Live births are occurring predominately in White and African-American populations. In 2008, 56% of all births to women ages 19 and under are to African-Americans. Seventy-eight percent of births are to women between 20 and 34 years. The percent of Hispanic/Latino live births to all ages have increased from 4% in 2006 to 6% in 2008.

MCH will continue to monitor the demographics of live births to women in order to evaluate the best provision for appropriate levels of service.

Health Status Indicators 07B: *Live births to women (of all ages) enumerated by maternal age and Hispanic ethnicity. (Demographics)*

HSI #07B - Demographics (Total live births)

CATEGORY Total live births	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Women < 15	133	4	0
Women 15 through 17	2440	143	2
Women 18 through 19	5936	245	5
Women 20 through 34	47790	2617	54
Women 35 or older	5284	340	97
Women of all ages	61583	3349	158

Notes - 2011

Narrative:
Please refer to data in FORM 21.

This measure provides information on the state's residents because it provides pregnancy information based upon these factors.

This measure provides guidance for age specific programs such as prenatal care, family planning, and direction of resources to the under or uninsured.

Live births are occurring predominately in White and African-American populations. In 2008, 56% of all births to women ages 19 and under are to African-Americans. Seventy-eight percent of births are to women between 20 and 34 years. The percent of Hispanic/Latino live births to all ages have increased from 4% in 2006 to 6% in 2008.

MCH will continue to monitor the demographics of live births to women in order to evaluate the best provision for appropriate levels of service.

Health Status Indicators 08A: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and race. (Demographics)*

HSI #08A - Demographics (Total deaths)

CATEGORY Total deaths	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	590	247	334	2	6	0	1	0
Children 1 through 4	115	46	69	0	0	0	0	0
Children 5 through 9	69	37	31	0	1	0	0	0
Children 10 through 14	64	26	38	0	0	0	0	0
Children 15 through 19	290	150	137	1	2	0	0	0
Children 20 through 24	518	276	234	3	4	0	1	0
Children 0 through 24	1646	782	843	6	13	0	2	0

Notes - 2011

Narrative:
Final data shows that there were fewer deaths for ages 0 through 24 years in 2007 (1,620 deaths) than in 2006 (1,674) and in 2005 (1,807). Though there were slightly more Caucasian deaths (801 or 49.4%) than African American deaths (749 or 49%) in 2007, they each represent about 49% of the total deaths. Also, most deaths were non-Hispanic (1,571 or 97%), and more were infants < age 1 year (594 or 36.7%), followed by young adults 20-24 years (498 or 30.7%), adolescents 15-19 years (299 or 18.4%), and children 1-14 years (229 or 14.1%).

For deaths of infants < age 1year (355 of 594) and young children ages 1-4 years (52 of 96), more than half, or about 59%, (407 of 690) were African American. However, for deaths of children and young adults in the 5-24 years age groups, more than half, or about 57% (529 of 930), were Caucasian. For Asians, 61.5% (8 of 13) of the deaths were of infants (4) and young children (4), whereas 23% (3 of 13) were of children 15-19 years. Of the 41 Hispanic deaths, 41.4% (17 of 41) were young adults 20-24 years followed by 29.3 % (12 of 41) infants < age 1 year, 17.1% (7 of 41) adolescents 15-19 years, 9.8% (4 of 41) children 1-4 years, and 2.4% (1 of 41) children 5-9 years. There were no Hispanic deaths of children 10-14 years.

This category of data will assist in directing public health efforts to reduce the number of deaths by identifying behavioral risk factors and the high risk groups based on age, race, and ethnicity

and addressing risk factors to change behaviors through targeted, preventive interventions, including education and outreach; appropriate allocation of resources; and legislation for public policy change. The data also serves as a public health call to action at the state and local/regional levels for the 9 regional MCH Child Safety Coordinators, the State and local Child Death Review Panels, community and state leaders as well as with the SIDS Risk Reduction and Safe Sleep Program, Injury Research and Prevention Program, and the Louisiana Youth Suicide Prevention Task Force.

Death rates are just one of several measures of our state's health status. Awareness of the leading causes of death can more efficiently and effectively target our efforts and resources toward building a healthier and safer community. As an evaluative measure, by comparing the state's death rates to past rates and to other states' rates, MCH can assess achievement of efforts, appropriateness of efforts, and effectiveness of preventive interventions and allocated resources over time.

Health Status Indicators 08B: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and Hispanic ethnicity. (Demographics)*

HSI #08B - Demographics (Total deaths)

CATEGORY Total deaths	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	573	15	2
Children 1 through 4	113	2	0
Children 5 through 9	68	1	0
Children 10 through 14	64	0	0
Children 15 through 19	282	8	1
Children 20 through 24	506	11	3
Children 0 through 24	1606	37	6

Notes - 2011

Narrative:
Final data shows that there were fewer deaths for ages 0 through 24 years in 2007 (1,620 deaths) than in 2006 (1,674) and in 2005 (1,807). Though there were slightly more Caucasian deaths (801 or 49.4%) than African American deaths (749 or 49%) in 2007, they each represent about 49% of the total deaths. Also, most deaths were non-Hispanic (1,571 or 97%), and more were infants < age 1 year (594 or 36.7%), followed by young adults 20-24 years (498 or 30.7%), adolescents 15-19 years (299 or 18.4%), and children 1-14 years (229 or 14.1%).

For deaths of infants < age 1year (355 of 594) and young children ages 1-4 years (52 of 96), more than half, or about 59%, (407 of 690) were African American. However, for deaths of children and young adults in the 5-24 years age groups, more than half, or about 57% (529 of 930), were Caucasian. For Asians, 61.5% (8 of 13) of the deaths were of infants (4) and young children (4), whereas 23% (3 of 13) were of children 15-19 years. Of the 41 Hispanic deaths, 41.4% (17 of 41) were young adults 20-24 years followed by 29.3 % (12 of 41) infants < age 1 year, 17.1% (7 of 41) adolescents 15-19 years, 9.8% (4 of 41) children 1-4 years, and 2.4% (1 of 41) children 5-9 years. There were no Hispanic deaths of children 10-14 years.

This category of data will assist in directing public health efforts to reduce the number of deaths by identifying behavioral risk factors and the high risk groups based on age, race, and ethnicity and addressing risk factors to change behaviors through targeted, preventive interventions, including education and outreach; appropriate allocation of resources; and legislation for public policy change. The data also serves as a public health call to action at the state and local/regional levels for the 9 regional MCH Child Safety Coordinators, the State and local Child Death Review Panels, community and state leaders as well as with the SIDS Risk Reduction and Safe Sleep Program, Injury Research and Prevention Program, and the Louisiana Youth Suicide Prevention Task Force.

Death rates are just one of several measures of our state's health status. Awareness of the leading causes of death can more efficiently and effectively target our efforts and resources toward building a healthier and safer community. As an evaluative measure, by comparing the state's death rates to past rates and to other states' rates, MCH can assess achievement of efforts, appropriateness of efforts, and effectiveness of preventive interventions and allocated resources over time.

Health Status Indicators 09A: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race. (Demographics)*

HSI #09A - Demographics (Miscellaneous Data)

CATEGORY Misc Data BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**	**Specific Reporting Year**
All children 0 through 19	1243358	717294	474924	8702	17873	617	23948	0	2008
Percent in household headed by single parent	43.0	0.0	0.0	0.0	0.0	0.0	0.0	43.0	2008
Percent in TANF (Grant) families	1.0	0.0	0.0	0.0	0.0	0.0	0.0	1.0	2008
Number enrolled in Medicaid	604395	214284	336697	1959	4716	283	5913	40543	2009
Number enrolled in SCHIP	130723	58546	59753	468	1453	63	1019	9421	2009
Number living in foster home care	4614	0	0	0	0	0	0	4614	2009
Number enrolled in food stamp program	278973	0	0	0	0	0	0	278973	2009
Number enrolled in WIC	155846	66620	82927	1576	1450	679	2594	0	2009
Rate (per 100,000) of juvenile crime arrests	1564.0	0.0	0.0	0.0	0.0	0.0	0.0	1564.0	2008
Percentage of high school drop-outs (grade	10.0	0.0	0.0	0.0	0.0	0.0	0.0	10.0	2008

9 through 12)									

Notes - 2011
Definitions: Children under age 18 who live with their own single parent either in a family or subfamily. In this definition, single-parent families may include cohabiting couples and do not include children living with married stepparents.
Data Source: Population Reference Bureau, analysis of data from the U.S. Census Bureau, Census 2000 Supplementary Survey, 2001 Supplementary Survey, 2002 through 2008 American Community Survey.
Updated September 2009. The data for this measure come from the 2000 and 2001 Supplementary Survey and the 2002 through 2008 American Community Survey (ACS). The 2000 through 2004 ACS surveyed approximately 700,000 households monthly during each calendar year. In general but particularly for these years, use caution when interpreting estimates for less populous states or indicators representing small subpopulations, where the sample size is relatively small. Beginning in January 2005, the U.S. Census Bureau expanded the ACS sample to 3 million households (full implementation), and in January 2006 the ACS included group quarters. The ACS, fully implemented, is designed to provide annually updated social, economic, and housing data for states and communities. (Such local-area data have traditionally been collected once every ten years in the long form of the decennial census.)
Single-parent families may include cohabiting couples and do not include children living with stepparents. Children who live in group quarters (for example, institutions, dormitories, or group homes) are not included in this calculation. Children in single-parent families.
Data Provided by: National KIDS COUNT Program

Percent: The average number of children served by the Family Independence Temporary Assistance Program (FITAP) in a state fiscal year (July 1-June 30) per 100 children.
Data Source: FITAP Numbers: Louisiana Department of Social Services, Office of Family Support, Quality Assurance Division. Population Data: Population Estimates Program, Population Division, U.S. Census Bureau Washington D.C. Release Date: August 7, 2008. Available at http://www.census.gov/popest/estimates.php
Footnotes: FITAP provides cash assistance to families with children when the financial resources of the family are insufficient to meet subsistence needs. The average family consists of a mother and two children. The average grant in Louisiana is $200 per month.

Because FITAP data are based on state fiscal year averages, population estimates for two years were averaged to calculate a FITAP participation rate per 100 children.

LNE (Low Number Event) is a value of fewer than 5 events or a rate based on fewer than 20 events and is thus not reported.
Data Provided by: Agenda for Children

From Medicaid: Unduplicated Count of Eligibles by Race FFY 2009 (October 2008- September 2009). Ages 0-19. Hispanic or Latino includes Hispanic or Latino (no other race information) AND Hispanic or Latino and one or more races. Ethinicity not reported includes Invalid Race Code AND More than One Race (Hispanic or Latino not indicated) AND Unknown.

From Medicaid: Unduplicated Count of Eligibles by Race FFY 2009 (October 2008- September 2009). Ages 0-19. Hispanic or Latino includes Hispanic or Latino (no other race information) AND Hispanic or Latino and one or more races. Ethinicity not reported includes Invalid Race Code AND More than One Race (Hispanic or Latino not indicated) AND Unknown.

The average number of children served by the Food Stamp program in a given state fiscal year (July 1-June 30).

Data Source: Food Stamp data: Louisiana Department of Social Services, Office of Family Support, Quality Assurance Division. No further ethnic or racial greakdown is available.

Data is for FFY 2009. The number was derived by adding the number of infants and children that participated in the reporting year, based on the average number of vouchers. This was found to be more accurate versus using unique identifiers. Past counts of unique identifiers included children later found to be ineligible or duplicates.

The racial and ethnic breakdown were derived from the PHAME Report. Information based upon Race/Idenity as entered into PHAME. This was used to pull a percentage of race and apply to the actual participation numbers. The participation numbers are not unique pass ID's, they reflect the actual number of people served (holding WIC benefits).

Data source: Analysis of arrest data from the FBI's Crime in the United States 2008 (Washington, DC: Federal Bureau of Investigation, 2009), tables 5 and 69, and population data from the National Center for Health Statistics' Estimates of the July 1, 2000–July 1, 2008, United States Resident Population From the Vintage 2008 Postcensal Series by Year, County, Age, Sex, Race, and Hispanic Origin [machine-readable data files available online at http://www.cdc.gov/nchs/nvss/bridged_race.htm, released 9/2/2009]. No further racial or ethnic breakdown is available.

Definitions: Teenagers between the ages of 16 and 19 who are not enrolled in high school and are not high school graduates. More...
Data Source: Population Reference Bureau, analysis of data from the U.S. Census Bureau, American Community Survey. Updated September 2009. Estimates suppressed when the confidence interval around the percentage is greater than 10 percentage points. N.A. – Data not available. No furtehr racial or ethnic breakdown is available.

Source: Louisiana Department of Social Services/Office of Community Services. Data is for Calendar Year 2009. No further racial or ethnic breakdwon is available.

Narrative:
Please refer to data in FORM 21.

This indicator provides information on the state's residents because it provides public health risk and health information based upon these factors.

This data provides guidance for race and ethnicity specific programs such as SCHIP, Medicaid and WIC. The data informs the MCH program in providing advice to other miscellaneous programs. This data informs and directs health and social marketing campaigns that address disparities in this population.

For children aged 0-19 years of age, Annie Casey Foundation 2009 Report ranks Louisiana 49th with 43% in a household with a single parent. For teenagers between the ages of 16 and 19 who are not enrolled in high school and are not high school graduates, Louisiana ranks 49th in the nation with a drop out rate at 10%. Louisiana's rate of juvenile arrests is 1,564 per 100,000 persons. This is compared to a national rate of 1,398 per 100,000 persons under the age of 18.

Health Status Indicators 09B: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by Hispanic ethnicity. (Demographics)*

HSI #09B - Demographics (Miscellaneous Data)

CATEGORY	Total NOT	Total	Ethnicity Not	Specific

Miscellaneous Data BY HISPANIC ETHNICITY	**Hispanic or Latino**	**Hispanic or Latino**	**Reported**	**Reporting Year**
All children 0 through 19	1193668	49690	0	2008
Percent in household headed by single parent	0.0	0.0	43.0	2008
Percent in TANF (Grant) families	0.0	0.0	1.0	2008
Number enrolled in Medicaid	563852	15582	24961	2009
Number enrolled in SCHIP	120591	3511	6621	2009
Number living in foster home care	0	0	4614	2009
Number enrolled in food stamp program	0	0	278973	2009
Number enrolled in WIC	145562	10284	0	2009
Rate (per 100,000) of juvenile crime arrests	0.0	0.0	1564.0	2008
Percentage of high school drop-outs (grade 9 through 12)	0.0	0.0	10.0	2008

Notes - 2011

Narrative:
Please refer to data in FORM 21.

This indicator provides information on the state's residents because it provides public health risk and health information based upon these factors.

This data provides guidance for race and ethnicity specific programs such as SCHIP, Medicaid and WIC. The data informs the MCH program in providing advice to other miscellaneous programs. This data informs and directs health and social marketing campaigns that address disparities in this population.

For children aged 0-19 years of age, Annie Casey Foundation 2009 Report ranks Louisiana 49th with 43% in a household with a single parent. For teenagers between the ages of 16 and 19 who are not enrolled in high school and are not high school graduates, Louisiana ranks 49th in the nation with a drop out rate at 10%. Louisiana's rate of juvenile arrests is 1,564 per 100,000 persons. This is compared to a national rate of 1,398 per 100,000 persons under the age of 18.

Health Status Indicators 10: *Geographic living area for all children aged 0 through 19 years.*

HSI #10 - Demographics (Geographic Living Area)

Geographic Living Area	**Total**
Living in metropolitan areas	755796
Living in urban areas	1233743
Living in rural areas	9615
Living in frontier areas	0
Total - all children 0 through 19	1243358

Notes - 2011
Source: US Department of Agriculture. The 2003 rural-urban continuum codes classify metropolitan counties (codes 1 through 3) by size of the Metropolitan Statistical Area (MSA), and nonmetropolitan counties (codes 4 through 9) by degree of urbanization and proximity to metro areas. See rural-urban continuum codes for precise definitions of each code.

Source: US Department of Agriculture. The 2003 rural-urban continuum codes classify metropolitan counties (codes 1 through 3) by size of the Metropolitan Statistical Area (MSA), and nonmetropolitan counties (codes 4 through 9) by degree of urbanization and proximity to metro areas. See rural-urban continuum codes for precise definitions of each code.

Source: US Department of Agriculture. The 2003 rural-urban continuum codes classify metropolitan counties (codes 1 through 3) by size of the Metropolitan Statistical Area (MSA), and nonmetropolitan counties (codes 4 through 9) by degree of urbanization and proximity to metro areas. See rural-urban continuum codes for precise definitions of each code.

Narrative:
Please refer to data in FORM 21.

This indicator provides information on the state's residents because it provides Public Health risk and health information by geographic area. Risk to children may be based upon rural or metropolitan living environments.

For children ages 0-19 years of age, 61% live in metropolitan areas with 99% living in urban areas. Only 1% of this population, lives in rural areas.

Health Status Indicators 11: *Percent of the State population at various levels of the federal poverty level.*

HSI #11 - Demographics (Poverty Levels)

Poverty Levels	Total
Total Population	4492076.0
Percent Below: 50% of poverty	9.4
100% of poverty	18.2
200% of poverty	40.0

Notes - 2011
Table 1. Annual Estimates of the Resident Population for the United States, Regions, States, and Puerto Rico: April 1, 2000 to July 1, 2009 (NST-EST2009-01). Source: U.S. Census Bureau, Population Division. Release Date: December 2009.

Source: QT-P34. Poverty Status in 1999 of Individuals: 2000 U.S. Census Bureau, Census 2000 Summary File 3, Matrices PCT 9, PCT50, PCT51, PCT52, PCT53, PCT 54, and PCT55.

Source: U.S. Census Bureau, Current Population Survey, 2009 Annual Social and Economic Supplement. POV46.

Source: U.S. Census Bureau, Current Population Survey, 2009 Annual Social and Economic Supplement. POV46.

Narrative:
Please refer to data in FORM 21.

Approximately 18% of the Louisiana population live below 100% of federal poverty level, with 9% in extreme poverty below 50%.

This measure provides information on the state's residents because it provides Public Health risk

and health information by poverty level. Risk to individuals may be evaluated based upon poverty level.

Health Status Indicators 12: *Percent of the State population aged 0 through 19 years at various levels of the federal poverty level.*

HSI #12 - Demographics (Poverty Levels)

Poverty Levels	Total
Children 0 through 19 years old	1243358.0
Percent Below: 50% of poverty	11.0
100% of poverty	23.3
200% of poverty	48.0

Notes - 2011

Definitions: The share of children under age 18 who live in families with incomes less than 50 percent of the federal poverty level, as defined by the U.S. Office of Management and Budget.
Data Source: Population Reference Bureau, analysis of data from the U.S. Census Bureau, Census 2000 Supplementary Survey, 2001 Supplementary Survey, 2002 through 2008 American Community Survey. Updated October 2009.
The data for this measure come from the 2000 and 2001 Supplementary Survey and the 2002 through 2008 American Community Survey (ACS). The 2000 through 2004 ACS surveyed approximately 700,000 households monthly during each calendar year. In general but particularly for these years, use caution when interpreting estimates for less populous states or indicators representing small subpopulations, where the sample size is relatively small. Beginning in January 2005, the U.S. Census Bureau expanded the ACS sample to 3 million households (full implementation), and in January 2006 the ACS included group quarters. The ACS, fully implemented, is designed to provide annually updated social, economic, and housing data for states and communities. (Such local-area data have traditionally been collected once every ten years in the long form of the decennial census.)
The federal poverty definition consists of a series of thresholds based on family size and composition. In 2000, a 50% poverty threshold for a family of two adults and two children was $8,731. Poverty status is not determined for people in military barracks, institutional quarters, or for unrelated individuals under age 15 (such as foster children). Children in extreme poverty.

Definition: The share of children under age 18 who live in families with incomes less than 150 percent of the federal poverty level, as defined by the U.S. Office of Management and Budget.
Data Source: Population Reference Bureau, analysis of data from the U.S. Census Bureau, Census 2000 Supplementary Survey, 2001 Supplementary Survey, 2002 through 2008 American Community Survey. Updated October 2009.
The data for this measure come from the 2000 and 2001 Supplementary Survey and the 2002 through 2008 American Community Survey (ACS). The 2000 through 2004 ACS surveyed approximately 700,000 households monthly during each calendar year. In general but particularly for these years, use caution when interpreting estimates for less populous states or indicators representing small subpopulations, where the sample size is relatively small. Beginning in January 2005, the U.S. Census Bureau expanded the ACS sample to 3 million households (full implementation), and in January 2006 the ACS included group quarters. The ACS, fully implemented, is designed to provide annually updated social, economic, and housing data for states and communities. (Such local-area data have traditionally been collected once every ten years in the long form of the decennial census.)
The federal poverty definition consists of a series of thresholds based on family size and composition. In 2000, a 150% poverty threshold for a family of two adults and two children was $26,195. Poverty status is not determined for people in military barracks, institutional quarters, or for unrelated individuals under age 15 (such as foster children). Children below 150% poverty.

Definitions: The share of children under age 18 who live in families with incomes less than 200 percent of the federal poverty level, as defined by the U.S. Office of Management and Budget. Data Source: Population Reference Bureau, analysis of data from the U.S. Census Bureau, Census Supplementary Surveys and American Community Survey. Updated October 2009. S - Estimates suppressed when the confidence interval around the percentage is greater than 10 percentage points. N.A. – Data not available. A 90 percent confidence interval for each estimate can be found at Children below 200% poverty.

Narrative:
Please refer to data in FORM 21.

In 2008, Annie Casey Foundation 2009 report 23% of children in Louisiana are living at the 100% of the poverty level with almost 50% at 200% of the poverty level. Children live in higher rates of poverty than the population as a whole.

This measure provides information on the state' children because it provides Public Health risk and health information by poverty level. Risk to children may be evaluated based upon poverty level.

F. Other Program Activities

Surveillance and Universal Screening
Louisiana's Childhood Lead Poisoning Prevention Program (LACLPPP) receives CDC and MCH funds to maintain a statewide, population-based surveillance system of blood lead levels of children ages 6-72 months, for case management and environmental inspections of children with elevated blood lead levels, and to support the New Orleans Childhood Lead Poisoning Prevention Program. Mandatory universal blood lead screening of children ages 6-72 months, and mandatory reporting of the screening results has been implemented in Louisiana since 2008 and LACLPPP has begun strategic planning to implement CDC's primary prevention initiative, "Healthy Homes", a community-level approach to healthy environments by integrating lead poisoning prevention with injury and asthma.

The Genetic Diseases Program, along with Public Health's Laboratory, operates a statewide Newborn Heal Stick Screening and Follow-up Program, which screens all newborns in the state before hospital discharge for all 28 of the disorders recommended by the American College of Medical Genetics, except for hearing loss. The Louisiana Newborn Screening Rule (LAC48:v.6303.08), effective January 2008, was amended to provide guidance to providers on the timing of collection of newborn screening and on post-transfusion collection of screenings.

The Injury Research and Prevention Program (IRPP), now integrated into MCH, receives CDC funds for Rape Prevention Education and for operating the following Louisiana. surveillance systems: Injury Mortality surveillance, Non-Fatal injury surveillance (Louisiana Hospital Inpatient Discharge Data), Traumatic Brain and Spinal Cord Injury Surveillance (legislatively mandated registry), and Child Death Review surveillance of unexpected deaths of children <15 yrs of age. IRPP also receives Preventive Health Block Grant funding to support primary prevention education for the leading causes of adult injury morbidity and mortality, such as falls (among the elderly) and motor vehicle crashes from distracted driving.

CSHS received a $947,403 CDC grant for the expansion of the Louisiana Birth Defects Monitoring Network, an active surveillance system that is an unfunded legislative mandate currently being supported almost entirely by Title V Block Grant funds. The program currently covers approximately 80% of births in the state, and plans to be statewide by the end of 2011.

The new program manager, a physician with disaster surveillance expertise, will work with CDC to select a new software system, work with IT to adapt it to meet Louisiana needs. With all births in the state included in the system, the program will be able to compute statewide statistics for incidence of birth defects identified by the network in order to develop specific prevention/intervention activities. Resource guide distribution to parents of infants identified by the system should improve with the new grant funding. CSHS has also received additional funds from MCHB to improve follow-up of infants identified by the newborn hearing screening program by transitioning to a web-based software program and improve data reporting. Coordination with the Parent Pupil Education Program of the School for the Deaf and Early Steps will also improve follow-up of infants identified by the program. CSHS is also participating in a DHH-DSS Data Integration Project to create a master patient database that will be accessible by programs from the two agencies and will be a way to improve care coordination by all programs, and will provide the possibility of "single point of entry" in to all programs for families. CSHS supports the project and requested to pilot it.

Coordination/Policy Development
BrightStart is Louisiana's HRSA-MCHB Early Childhood Comprehensive Systems Grant Initiative, a framework of systems integration and public/private partnerships, which functions under the auspices of the Louisiana Governor's Children's Cabinet and the Advisory Board, with the MCH Program providing guidance to the administrative management of the grant initiative. The MCH principal investigator and 2 coordinators oversee all grant activities carried out by Focus Area work groups, representing child safety and the priority areas of the grant: access to health care, early care and education, social-emotional/mental health, family support, and parenting education. BrightStart's Steering Committee was designated by Governor Jindal as Louisiana's Early Childhood Advisory Council in December 2009 and is now called BrightStart Advisory Council. Successes included a completed needs assessment and inventory of current home visiting programs in Louisiana and formed a Home Visiting Advisory Council for input; a website (www.brightstartla.org); an Early Childhood System Integration Budget (2008 Louisiana legislature, Act 774), with the 5 ECCS priority areas as reporting categories; coordination of multi-agency infant mental health training; Quality Start, the childcare rating system managed by DSS, with more than 47% Class-A licensed centers participation; and Louisiana Parent Educators Network, which launched a website (www.lapen.org/registry) and a Parent Educator Registry, hosted its 3rd Annual Summit (March 1, 2010), and developed a Parenting Education Track for the Prevent Child Abuse Louisiana Conference (March 2-3, 2010).

Toll Free Hotline
MCH funds the statewide Partners for Healthy Babies (PHB) social marketing campaign which uses multimedia approaches to promote healthy behaviors during pregnancy, early entry into prenatal care, reduction of risky behaviors, and in the past year, preconception health. A fundamental component of PHB is the Title V-funded toll-free, 24- hr helpline, 1-800-251-BABY (operated by the American Pregnancy Association, Inc.) and corresponding website, www.1800251BABY.org to link women, and their families, to prenatal care, other health services and to enabling support services in their area (i.e. WIC and Medicaid enrollment information and centers). The hotline received 2,950 calls in 2008 and 4,274 in 2009, and the website had 14,105 hits in 2008 and 10,735 in 2009. The most recent focus area is the preconception health campaign, The Stork Reality which reaches out to women (and men) who are not actively seeking to get pregnant, using traditional media, social media (Facebook/Twitter), and interactive web advertising. Tulane University School of Public Health, Community Health Sciences faculty provide oversight of this population-based health promotion efforts.

G. Technical Assistance

Technical assistance needs are described in Form 15. Please see this form for a complete list of anticipated needs.

V. Budget Narrative

Budget and expenditure data from Forms 3, 4, and 5 are provided for the application year, interim year, and reporting year to assist the reviewer in analysis of the budget and expenditure narrative. For complete financial data, refer to all the financial data reported on Forms 2-5, especially when reviewing the federal allocation on Form 2 for the 30%/30%/10% breakdown for the budgets planned for primary and preventive care for children, children with special health care needs, and administrative costs.

Form 3, State MCH Funding Profile

	FY 2009		FY 2010		FY 2011	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
1. Federal Allocation *(Line1, Form 2)*	13491772	11991772	13363275		13360844	
2. Unobligated Balance *(Line2, Form 2)*	2370420	2370420	1739358		1203156	
3. State Funds *(Line3, Form 2)*	23712908	23518141	24946186		24910587	
4. Local MCH Funds *(Line4, Form 2)*	867504	871318	952266		943936	
5. Other Funds *(Line5, Form 2)*	0	2491317	0		3700000	
6. Program Income *(Line6, Form 2)*	9145374	8920802	9838258		7247628	
7. Subtotal	49587978	50163770	50839343		51366151	
8. Other Federal Funds *(Line10, Form 2)*	731366	715187	871880		1472191	
9. Total *(Line11, Form 2)*	50319344	50878957	51711223		52838342	

Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds

	FY 2009		FY 2010		FY 2011	
I. Federal-State MCH Block Grant Partnership	**Budgeted**	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
a. Pregnant Women	8803410	10064485	8434455		10500000	
b. Infants < 1 year old	9702217	9107492	12138344		9500000	
c. Children 1 to 22 years old	16752697	16465776	15366017		16600000	
d. Children with	8640275	8220080	8620258		8300000	

Special Healthcare Needs						
e. Others	2087433	1251945	1669647		1265000	
f. Administration	3601946	5053992	4610622		5201151	
g. SUBTOTAL	49587978	50163770	50839343		51366151	
II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).						
a. SPRANS	0		0		0	
b. SSDI	94644		94644		94966	
c. CISS	0		0		0	
d. Abstinence Education	0		0		0	
e. Healthy Start	0		0		0	
f. EMSC	0		0		0	
g. WIC	0		0		0	
h. AIDS	0		0		0	
i. CDC	0		0		0	
j. Education	0		0		0	
k. Other						
Birth Defects	0		0		205000	
Early Childhood	140000		245000		140000	
Early Hearing	0		0		150000	
Newborn Screening	0		0		300000	
Oral Health	200740		114590		437015	
PRAMS	145982		145210		145210	
Perinatal depression	0		272436		0	
Perinatal Depression	150000		0		0	

Form 5, State Title V Program Budget and Expenditures by Types of Services (II)

	FY 2009		**FY 2010**		**FY 2011**	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
I. Direct Health Care Services	19561277	18026986	18302163		18459076	
II. Enabling Services	16610817	19998150	18793770		20477487	
III. Population-Based Services	11352345	10171361	11201442		10415159	
IV. Infrastructure Building Services	2063539	1967273	2541968		2014429	
V. Federal-State Title V Block Grant Partnership Total	49587978	50163770	50839343		51366151	

A. Expenditures

On Form 3, the expended amount for Federal Allocation was lower than the budgeted amount for Federal Allocation due to increase in Other Funds from additional Temporary Assistance for Needy Families funding for Nurse Family Partnership awarded for FY 2009 for program expansion.

On Form 3, the expended amount for Other Funds was higher than the budgeted because after the Title V Budget was submitted for 2009, additional Temporary Assistance for Needy Families (TANF) Funding for Nurse Family Partnership was awarded for FY 2009 for program expansion.

On Form 4, the expended amount for Pregnant Women was higher than the budgeted amount due to overall program increase in expenditures for the expansion of the Nurse Family Partnership Program for this category.

On Form 4, the expended amount for All Others was lower than the budgeted amount due to an increase in Medicaid revenue for the Family Planning Program which decreased the federal allocation.

On Form 4, the expended amount for Administration was higher than the budgeted amount due to the DHH Information Technology Department being transferred from Office of Public Health (previously reported as direct charges) to the DHH Office of Secretary (now reported as overhead/administration charges).

On Form 5, the expended amount for Enabling Services was higher than the budgeted amount because after the Title V Budget was submitted for 2009, additional Temporary Assistance for Needy Families (TANF) Funding and State General Funds for Nurse Family Partnership was awarded for FY 2009 for program expansion.

On Form 5, the budgeted amount for Population-Based Services was higher than the expended amount due to the FY 2009 budgeted amount being set too high. The budgeted for Population-Based Services anticipated expansion and growth but not as much growth in Population-Based Services as expected was achieved.

B. Budget

The following services and programs are funded by the MCH Block Grant, Title XIX, patient fees, insurance reimbursements, state, and local funds:

1. Maternity
2. Family Planning Program
3. Child Health - Preventive/primary services for children birth to 21.
4. Immunization Program
5. Children's Special Health Services/Genetics Program
6. Adolescent and School Health

The MCH Block Grant supports the state and regional administrative and consultative staff who are responsible for setting standards of care, developing policies and programs, training field staff, providing quality assurance, and conducting surveillance. The amount budgeted for the state Office of Public Health MCH and CHSCN Programs represents the cost of building the capacity of the state to meet the goals and objectives and address the priority needs of the MCH and CSHCN Programs. In addition, other core public health services, direct personal health services, enabling services, and population-based services are included in the following budget. The amounts for each of the MCH population sub-groups are presented in the attachment Budget Table 2011, Tables 1, 2 and 3.

The service areas (reporting categories), which relate to preventive and primary care services for children, are provided in Table 2 (see attachment Budget Table 2011). The amount of funds budgeted in these service areas for fiscal year 2011 exceeds 30 percent of the total MCH Block grant. Thus, there is no need to redirect the MCH program in order to comply with this requirement. Compliance verification based on the actual funds disbursed will be performed and

documented by the Fiscal Office at the end of each state fiscal year.

A minimum of 30 percent of federal funds received for use in subsequent fiscal years and the associated match will be budgeted for use in programs that provide services for children with special health care needs. The amounts listed on Table 3 (see attachment) will be budgeted for fiscal year 2011. Compliance verification based on the actual funds disbursed will be performed and documented by the Fiscal Office at the end of each state fiscal year.

Sources of State Match and Overmatch Funds
Funds for Maternal and Child Health Services will be obtained from state general funds.

Program Income
Program income comes from Title XIX funds, Temporary Assistance for Needy Families (TANF) funds, fees, and third party payers. Table 4 (see attachment) presents the distribution of this income by program component.

Budgeting for Cross cutting Programs
The Office of Public Health is able to associate all expenditures including each staff person's work activity with the correct funding source by a system using reporting categories. The Office of Public Health budget is divided into many service areas, each identified by a reporting category. Most Office of Public Health employees utilize this Reporting Category system to allocate their time and other expenditures to a particular project or service area. This system allows staff working across many programs to allocate their time and other expenditures appropriately.

Use of Overmatch Funds
There is no overmatch that is under the control of the State Title V Agency that is used to match other federal programs.

Fees
Maternal and child health patients receiving services at parish health units and are above 100% of the poverty level are charged $5 per clinic visit and $5 for pharmacy services. Individuals receiving only immunizations, and that are above 100% of the poverty level, are charged $10.00. Family planning patients are charged fees according to a sliding fee scale.

Administrative Costs
Administrative costs are the portion of costs incurred by the following service units that are directly allocated to Maternal and Child Health Services Programs in accordance with Sections 3 and 5 (where applicable) of the Department of Health and Hospitals Cost Allocation Plan:

Office of Assistant Secretary-Management Information Systems (MIS)
Human Resources Section - Policy, Planning and Evaluation
Administrative Services Operations and Support Services
Statewide Costs (Purchasing, Civil Service, Treasurer, Fiscal, etc.)

Collectively these are referred to as Executive Overhead costs. Compliance verification of the 10 percent administrative restriction will be performed and documented by the Fiscal Office at the end of each state fiscal year. The estimated administrative costs for the total budget are $5,201,151 for fiscal year 2010-2011. The estimated Federal share is $1,336,084 or 10.0% of the federal funds requested.

Administrative Cost Limit - The administrative budget represents no more than 10.0% of the federal funds requested.

"30-30" Minimum Funding Requirements - The preventive and primary care services for children represent 33.9% of the Block Grant and Children with Special Health Care Needs represent 30.0% of the Block Grant budget. The definitions and descriptions of the services for these

project components can be found in the program narratives.

Administrative Cost Limit - The administrative budget represents no more than 10.0% of the federal funds requested.

Maintenance of State Effort - The State Office of Public Health intends to pursue and expects to obtain state general funds for Maternal and Child Health Services that equals or exceeds the level of such funds provided during state fiscal year 1989. Compliance verification will be performed and documented by the Fiscal Office at the end of each state fiscal year. The state support in state fiscal year 1989 was $6,207,276.

Allocation for Activity Conducted to Continue Consolidated Health Programs
The following federally funded programs were consolidated by the Maternal and Child Health Block Grant in fiscal year 1981-82 in Louisiana:
1. Maternal and Child Health Program;
2. Crippled Children's Services Program (in Louisiana called Children's Special Health Services);
3. Supplemental Security Income/Disabled Children's Program
4. Lead Based Paint Poisoning Prevention Program (previously funded only in City of New Orleans in Louisiana);
5. Genetic Diseases Program (incorporated previous funds for sickle cell disease at Flint Goodridge Hospital in New Orleans);
6. Sudden Infant Death Syndrome (SIDS) not funded in Louisiana; and
7. Adolescent Pregnancy Program not funded in Louisiana.

The following state funded programs in effect in Louisiana at the time of Block Grant Legislation in 1981 were also incorporated into the Maternal and Child Health Block Grant:
1. Genetic Diseases Program statewide screening for certain inherited disorders such as PKU, hypothyroidism, and sickle cell anemia.
2. Sudden Infant Death Syndrome (SIDS) Program follow up and counseling of affected families statewide.

Special Projects In Effect Before August 31, 1981
1. Maternal and Infant Care Project discontinued;
2. Children and Youth Project discontinued;
3. Family Planning absorbed into general Family Planning Program; Title V funding for Family Planning Program is budgeted at $1,000,000;
4. Dental Health for Children reduced services; current funding for Dental Services for Children's Special Health Services New Orleans District Office;
5. Neonatal Intensive Care absorbed by Louisiana State University Medical Center in Shreveport.

An attachment is included in this section.

VI. Reporting Forms-General Information
Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets
For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

For the detail sheets and objectives for the state performance measures developed from the 2010 needs assessment, refer to TVIS Forms, Form 11 and Form 16 under the section “New State Performance Measure Detail Sheets and Data.

VIII. Glossary
A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note
Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents
A. Needs Assessment
Please refer to Section II attachments, if provided.

B. All Reporting Forms
Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents
Please refer to Section III, C "Organizational Structure".

D. Annual Report Data
This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.